Application for a Â§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 waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

The State is seeking to renew Alabama's Home and Community-Based 1915(c) State of Alabama Independent Living (SAIL) Waiver. This renewal application will include additional services that will prevent or delay institutionalization by improving the quality of life and health and safety of Waiver recipients. This renewal application proposes to make the following changes under this Section 1915(c) Waiver:

Addition of Supervisory Visits

Increase the Medical Supply benefit limit

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*):

State of Alabama Independent Living (SAIL) 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.0241
Draft ID: AL.007.07.00

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

Regular Waiver

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

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:

The State does not limit 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.

The State of Alabama Independent Living Waiver (SAIL) provides home and community-based services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 63, who would otherwise require nursing facility care. The disease(s) or condition(s) are: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke, and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehon Syndrome.

This waiver aims at providing quality and cost effective services to individuals at risk of institutional care. The Alabama Medicaid Agency (Medicaid) is the Administering Agency for this program and the Alabama Department of Rehabilitation Services (ADRS) serves as the Operating Agency.

The following services are provided in the SAIL Waiver program: Case Management, Personal Care, Personal Assistance Service, Environmental Accessibility Adaptions, Personal Emergency Response System (initial and monthly), Medical Supplies, Minor Assistive Technology, Assistive Technology (evaluation and repairs), Unskilled Respite, Pest Control, and Supervisory Visits. SAIL also provides Transitional Services from an institution to the community through Case Management, Environmental Accessibility Adaptions and Assistive Technology.

This waiver includes a self directed care option called Personal Choices. Personal Choices is a state plan option available under the 1915(j) authority. Personal Choices provides individuals the opportunity to have control and choice in identifying, accessing, and managing their long term services and community supports. This option allows self-direction for Personal Care, Personal Assistance, and Unskilled Respite Services. All participants are given the opportunity to choose between the Personal Choices Program and traditional waiver services through the SAIL waiver.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **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:

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: Burris

First Name: Jessie

Title: Program Manager

Agency: Alabama Medicaid Agency

Address: 501 Dexter Avenue

Address 2: P O Box 5624

City: Montgomery

State: **Alabama**

Zip: 36103-5624

Phone: (334) 242-5966 **Ext:** ☐ **TTY**

Fax: (334) 353-4182

E-mail: jessie.burris@medicaid.alabama.gov

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

Last Name: Alford

First Name: Lisa

Title: SAIL Division Director

Agency: Alabama Department of Rehabilitation Services

Address: 560 South Lawrence

Address 2:

City: Montgomery

State: **Alabama**

Zip:

36104

Phone:

(334) 293-7040 **Ext:** ☐ **TTY**

Fax:

(334) 293-7377

E-mail:

lisa.alford@rehab.alabama.gov

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alabama**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Alabama Department of Rehabilitation Services/SAIL Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

As the single state Medicaid agency, Alabama Medicaid has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. Alabama Medicaid has final approval of rules, regulations and policies pertaining to the SAIL Waiver and provides monitoring and ongoing oversight of this waiver program.

Alabama Medicaid's responsibilities include:
•Performing annual reviews to assure the provisions of the interagency agreement with the operating agency are met, which include a review of provider records, plans of care, staff qualifications and training, and case management services and monitoring.
•Providing periodic trainings to discuss policies and procedures in an effort to interpret and apply policies related to the program consistently.
•Conducting joint trainings with direct service providers enrolled in the SAIL Waiver Program.
•Reviewing National Core Indicator – Adults and Disabilities Survey results, which assess Alabama's performance of their programs and delivery systems for older adults and people with disabilities
•Conducting random sampling of level of care applications and plans of care on a quarterly basis to assure correct level of care determinations and adequate documentation.
•Reviewing all contracts between ADRS and their providers.

Alabama Medicaid has a Memorandum of Understanding with the Alabama Department of Rehabilitation Services (ADRS) to operate the SAIL Waiver. As the operating agency, ADRS is responsible for
•Admission, evaluation, and reevaluation of applicants and participants.
•Arranging and ongoing monitoring of all waiver services provided to participants.
•Verifying that subcontractors and service providers meet the qualified provider requirements initially and annually.
•Performing the activities related to the Personal

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.:*

Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid Agency and/or operating agency, The Alabama Medicaid Agency contracts with Alabama Department of Rehabilitation Services to complete the eligibility and enrollment of waiver recipients.

○ **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:

Alabama Medicaid meets these objectives by conducting quarterly and annual reviews of ADRS. Alabama Medicaid Quality Nurse Reviewers conduct the review using a random sampling of recipient records to ensure:

1. Level of care and admission criteria are met
2. Plan of care is appropriate
3. Freedom of choice is explained and documented
4. Patient rights are explained
5. Services reimbursed by Medicaid were provided The general objectives of the audits are:

1. To determine the effectiveness of the HCBS Waiver Quality Assurance Program.
2. To assure waiver participants have access to waiver services through the process of monitoring quality assurance procedures.
3. To assure waiver participants are able to exercise the right of freedom of choice of waiver services and providers, and to choose between home and community based services and institutionalization.
4. To assure the health and welfare of waiver participants, and to identify, address, and prevent abuse, neglect and exploitation of individuals served by the waiver.
5. To assure waiver participants are receiving services identified in the plan of care by qualified personnel through monitoring a sample of recipient records and personnel records.
6. To assure implementation and ongoing utilization of quality assurance standards of ADRS, Alabama Medicaid, and the Centers for Medicare and Medicaid Services through evaluation of direct service providers (DSP) and reports of quality assurance activities.

Alabama Medicaid Quality Assurance conducts quarterly meetings with the ADRS operating agencies to discuss topics such as provider issues.

Alabama Medicaid reviews the policies, procedures, organizational structure and staff qualifications of ADRS annually to ensure the operating agency is operating in accordance with waiver guidelines.

Alabama Medicaid reviews documentation of contractual agreements between ADRS and the DSPs annually to ensure that qualified providers are rendering services to Medicaid Waiver recipients.

Alabama Medicaid audits ADRS documentation of quality assurance (QA) visits to DSP to ensure:

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

ADRS complaint and grievance procedures are reviewed annually to ensure:

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

Alabama Medicaid may conduct random visits to client homes to determine:

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

Appendix A: Waiver Administration and Operation

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:

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:
Percent of data reports (i.e. data/administrative) specified in the agreements, policies and procedures with the Medicaid Agency that were submitted on time and in the correct format by the OA and validated by AMA for compliance. NUMERATOR [Number of reports submitted timely and in the correct format by the OA and validated by AMA.]/ DENOMINATOR [Number of data reports due.]

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90% confidence level +/- 10% 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**
	☐ **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 total reported performance measures that were above 86%.
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:
Number and percent of self-directed employees who have a Medicaid Provider Enrollment Agreement with the FMSA. NUMERATOR [Number of existing self-directed employees who have a Medicaid Provider Enrollment Agreement]/ DENOMINATOR [Number of existing self-directed employees]

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMSA Data

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Cont'd from above: issued by the OA] OA Programmatic operating procedures submitted

for review, as documented in the AMA Program Manager Log

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

Data Aggregation and Analysis:

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

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 special reports (i.e., Ad Hoc) requested by AMA and submitted by the OA that have been validated by the designated AMA Program Manager for program compliance. NUMERATOR [Number of special reports submitted by the OA that have been validated by the AMA Program Manager for program compliance]/ DENOMINATOR [Number of special reports submitted by the OA]

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of standard and expedited grievances that were resolved within the timeframes as validated by AMA. NUMERATOR [Number of standard and expedited grievances that were resolved within the required timeframes as validated by AMA] / DENOMINATOR [Number of standard and 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.

Alabama Medicaid exercises administrative authority and responsibility of all waiver related policies and ADRS's adherence

to rules and regulations governing the State of Alabama Independent Living (SAIL) Waiver. Alabama Medicaid conducts quarterly and as needed meetings with ADRS to disseminate policies, rules and regulations in an effort to ensure consistent application of the policies related to SAIL Waiver.

Alabama 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 Care Plan (PCCP); and the monitoring of service providers contracted with ADRS.

Alabama Medicaid monitors the Quality Improvement Strategy (QIS) of the waiver on an ongoing basis. If a problem is identified, Alabama Medicaid sends a notice to ADRS 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. Based on information gathered through the analysis of the Quality Assurance data and daily program administration, Alabama Medicaid Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training is sufficient, or if a system change is required. Additional performance indicators and policy standards may be added to the Alabama Medicaid QIS.

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.

Alabama Medicaid has developed a Quality Management Strategy for the SAIL Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing data quarterly to monitor appropriateness of level of care determinations; (2) Collect data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant homes, conduct consumer satisfaction surveys, and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.

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**			☐
	☒	**Disabled (Physical)**	18	63	
	☐	**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**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

This waiver specifically provides services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 63. The disease(s) or condition(s) are: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke, and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch- Nyhan Syndrome.

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:

Waiver participants entering the program prior to age 63 will remain on the program after reaching the age of 63 as long as the LOC criteria is met annually. Those persons who are age 63 or older who received a diagnosis prior to reaching the age of 63 and have sufficient medical documentation can be admitted into the waiver. Those persons receiving a diagnosis after turning age 63 are not eligible for the SAIL Waiver and referred more appropriate waiver programs. A referral will also be made to a Community Support Specialist who will work with the individual to provide information on other resources to help meet the individual needs within the community. The Community Support Specialist is employed through ADRS and is available as needed to those who qualify in the community and can provide short-term services for the enhancement of independent living.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	800
Year 2	800
Year 3	800
Year 4	800
Year 5	800

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
Individuals who transfer from nursing facilities back into the community.

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):*

Individuals who transfer from nursing facilities back into the community.

Purpose *(describe):*

The purpose of reserving these slots is to assist Alabama Medicaid eligible recipients who desire to transition from nursing facilities back into the community. The reservation of these slots will allow those individuals who are able to transition to be placed in a reserved waiver slot during the current waiver year.

Describe how the amount of reserved capacity was determined:

The Operating Agency has estimated that 10 slots would be the amount needed to place in reserve for individuals transitioning from the nursing facility to the waiver.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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:

ADRS utilizes a screening tool referred to as the SAIL Referral Form. Upon initial contact, the Intake Coordinator completes the Referral Form for all persons seeking entry onto the waiver. If appropriate for further assessment and a waiver slot is available, the Case Manager will begin the application process by contacting the applicant in five (5) business days and scheduling a home visit to complete the HCBS-1 application within thirty (30) business days.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [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)**

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

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.137, 435.138, Section 6 of Public Law 99-643, individuals eligible under 42 CFR 435.145, 435.227, 435.115, 435.116, 435.117 and 435.118.

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:

The state uses post-eligibility rules for the period between January 1, 2014 and September 30, 2027 as per section 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the state plan**

  Select one:

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

    (*select one*):

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

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - (●) **Other standard included under the state plan**

    Specify:

    The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which included income placed in a Miller Trust.
- ( ) **The following dollar amount**

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

  Specify:
- ( ) **Other**

  Specify:

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

- ( ) **Not Applicable**

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

Specify:

The State is using post-eligibility rules for the period January 1, 2014 through September 30, 2027 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

The State is using post-eligibility rules for the period January 1, 2014 through September 30, 2027 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

in 42 CFR § 435.726:

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage: [ ]

○ **The following dollar amount:**

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

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

Specify formula:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income 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:

Nurses employed by ADRS must be licensed by the State of Alabama or hold a multistate license under the nurse licensure compact (NLC). A nurse holding a multistate license is entitled to practice in any NLC party state, but must comply at all times with the laws of the state where he or she currently is practicing. Candidates for employment must meet the minimum qualifications as defined by the State of Alabama Personnel Department for entry onto the list of qualifying candidates. The minimum qualifications are:
Bachelor's degree from an accredited four-year college or university in nursing or an Associate's degree from an accredited college or university in nursing or diploma in nursing and two years of professional nursing experience
Additional Requirements:
Alabama professional nursing license as issued by the Alabama Board of Nursing or NLC; license number must be included on the application. SAIL also prefers those candidates that have experience in home health nursing.

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

The SAIL Waiver recipients must meet the nursing facility (NF) level of care (LOC). The tool used to determine the NF LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form. New admissions and re-determinations must meet two of the criteria listed in A-K. Supporting documentation must be submitted with the application. The medical form of the LOC application must be signed by a physician, a nurse practitioner, or a physician assistant.

The admission criteria is as follows:

A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment. (Cannot be counted as a second criterion if used in conjunction with criterion K-7)

B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.

C. Nasopharyngeal aspiration required for the maintenance of a clear airway

D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created. (Cannot be counted as a second criterion if used in conjunction with criterion K-3 if the ONLY stoma (opening) is a G or PEG tube.)

E. Administration of tube feedings by naso-gastric tube.

F. Care of extensive decubitus ulcers or other widespread skin disorders.

G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse. (Cannot be counted as a second criterion if used in conjunction with criterion K-9)

H. Use of oxygen on a regular or continuing basis.

I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders.

J. Comatose client receiving routine medical treatment.

K. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer- The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or two or more times per week).

2. Mobility- The individual requires physical assistance from another person for mobility on an ongoing basis (daily or two or more times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane or other mobility aid shall not by itself be considered to meet this requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement. (Cannot be counted as a second criterion if used in conjunction with criterion D if the ONLY stoma (opening) is a G or PEG tube.)

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care on an ongoing basis (daily or two or more times per week).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language: or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform of complete

basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes but not limited to, reminding when to take medications, encouragement to take reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (Cannot be counted as a second criterion if used in conjunction with criterion A)

8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia- related behavioral problems (e.g., aggressive physical behavior, disrobing or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - the individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than for practical purposes would be provided through a daily home health visit. Cannot be counted as a second criterion if used in conjunction with criterion G)

Criterion K should reflect the individuals capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.

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

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

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

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

Evaluation:
Waiver applicants for whom there is a reasonable indication that services may be needed are provided an individual Level of Care (LOC) evaluation. The case manager performs a thorough assessment of the participant's living situation, their ability to perform activities of daily living, available community resources, support from family/others and develops a Person Centered Care Plan (PCCP) to address any gaps which place the participant at risk for institutionalization. Medical certification is obtained by the case manager from the attending physician. Information gathered by the case manager and the attending physician is forwarded to the ADRS Nurse Reviewer for a Level of Care determination. A Level of Care determination for a participant is processed based upon information contained on the HCBS-1 assessment as well as physician progress notes and/or hospital records as needed or requested by the nurse reviewer. The Nurse Reviewers evaluate the application to make sure it is complete, supports the need for waiver services, establishes that risk of nursing home placement and that medical criteria are met before level of care is approved. Consideration is also given to the functional limitation of the participant, medical diagnosis, support systems in place and any other factors which put the participant at risk for institutionalization. Applicants must meet two criteria as defined in B-6(d)above.

Alabama Medicaid has granted the ADRS Nurse Reviewers the authority to make the level of care determinations. During the audits of the ADRS, Alabama Medicaid Quality Nurse Reviewer may also review applications to determine if the level of care is appropriate.

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

Reevaluations:
At annual reevaluation participants are required to meet two criteria as defined in B-6(d) above for continued eligibility. A review includes meeting the level of care criteria as developed by the Alabama Medicaid Agency and the assessment of the support systems within the home, the functional limitations of the participant, the diagnosis and any factors that would place the participant at risk of institutionalization.

Reevaluations of eligibility for the SAIL Waiver must be completed at least every twelve months. This process utilizes the same application packet as the initial application and includes a level of care evaluation and PCCP. Reevaluations must be done on a timely basis so that services and payment will not be interrupted.

Case Managers also keep a copy of the participant's reevaluation dates in a tickler file to ensure timely re-evaluations are completed.

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

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

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

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

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

Reevaluations of eligibility for the SAIL Waiver must be completed at minimum every twelve months. The reevaluation process uses the same application packet as the initial eligibility determination which includes a level of care determination and PCCP.

PROCEDURE:

The ADRS Case Manager must complete the re-determination application, the HCBS Medical Form, and obtain medical documentation to support the re-determination, if applicable. The Case Manager will route this packet of information to the ADRS Nurse Reviewer to determine the Level of Care (LOC).

If the application requires Medicaid financial approval, the ADRS Nurse Reviewer will complete and attach the Waiver Medical Form/Waiver Slot Confirmation Form (Form 376) to the packet and submit it to the Alabama Medicaid Agency for processing. The Medicaid District Office will issue a financial award notice or denial notice to the participant; a copy of the notice will be transmitted by the Medicaid District Office to ADRS. Once ADRS receives the financial award notice the application will be processed into the LTC Admission Notification software.

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

All evaluations and reevaluations are maintained for a minimum period of 3 years. The participant records are located at ADRS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Cont'd from above: 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. NUMERATOR [Number of participants who have a level of care (LOC) evaluation completed prior to entry into the HCBS waiver]/ DEMONINATOR [Number of participants who entered the HCBS Waiver]

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Application and Enrollment Data

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

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

Data Aggregation and Analysis:

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

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 LOC determinations where the LOC instruments and processes were appropriately applied and according to the approved description in the approved waiver needs criteria. NUMERATOR:[Number of LOC determinations where the LOC instruments and processes were appropriately applied and according to the approved description in the approved waiver]/ DENOMINATOR [Number of LOC determinations]

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

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

		95% confidence level +/- 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**
	☐ **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.

Alabama Medicaid has granted the Alabama Department of Rehabilitation Services (ADRS) Nurse Reviewer the authority to make the level of care (LOC) determinations and annual redeterminations (re-evaluations). The Alabama Medicaid Nurse Reviewer will randomly select a percentage of applications for a quarterly retrospective review. The Alabama Medicaid Nurse Reviewer will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes when necessary, and/or any other documentation to support the participant's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (reevaluation) must be completed every twelve months. Alabama Medicaid conducts quarterly Quality Assurance meetings. These meetings are designed to inform, educate, discuss matters of concern, etc.

b. Methods for Remediation/Fixing Individual Problems

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

Alabama Medicaid Waiver Quality Assurance has developed a Quality Management Strategy for the SAIL Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing quarterly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant homes, and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting ADRS to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, ADRS will be monitored every three months until compliance is achieved.

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.

ADRS will provide AMA with a Quarterly report on performance measures designated in the waiver application.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Freedom of Choice: Informed of feasible alternatives under the waiver.

Participants and/or responsible parties are provided with verbal and written information to make an informed decision as to the participant's care. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the participant, both formal and informal, as well as those waiver services which may be available to meet the participant's needs and those needs which cannot be met. Participants and/or their representative are given information to support them in making informed choices based upon their personal preferences. Risks are identified and risk mitigation strategies are discussed and agreed to by the participant. This information is reviewed at least annually.

Freedom of Choice: Given the choice of either institutional or home and community based services.

Information is provided verbally and in writing. Each waiver participant must make a written choice for either institutional or community care upon admission and at least annually thereafter by signing the freedom of choice statement on the Admission and Evaluation Data form (HCBS-1, page 3), which serves as documentation of the individual's choice.

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

The forms are maintained for a minimum of three years in ADRS Case Records.

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 are made for Limited English Proficiency (LEP) persons includes 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. ADRS also partners with other divisions of ADRS for access to ASL certified interpreters, and all forms are available in English and Spanish.
Through the translators the participant can request and receive available Medicaid assistance and apply for Medicaid services.

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	Case Management		
Statutory Service	Personal Care		
Statutory Service	Unskilled Respite		
Extended State Plan Service	Medical Supplies		
Other Service	Assistive Technology Repairs		
Other Service	Assistive Technology		
Other Service	Environmental Accessibility Adaptations (EAA)		
Other Service	Evaluation for Assistive Technology		
Other Service	Minor Assistive Technology		
Other Service	Personal Assistance Service (PAS)		
Other Service	Personal Emergency Response System (Installation)		
Other Service	Personal Emergency Response System (Monthly Fee)		
Other Service	Pest Control Service		
Other Service	Supervisory Visit		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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

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

The unit of service will be per 15 minute increments commencing on the date that the participant is determined eligible for the State of Alabama Independent Living (SAIL) Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required each month in addition to any other case management activities. A unit of service for Case Management that assists in the transitioning of individuals from institutional settings into the community will be per 15 minute increments beginning on the first date the case manager goes to the institution to complete an initial assessment.

There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager have monthly contact with the participant or sponsor. For Transitional CM a unit of service that assists participants transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. If Transitional CM is provided it should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the participant fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the plan of care development and signing the service authorization log if the recipient is unable to do so. The ADRS Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

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	State Agency--Case Management staff are employees of a state agency (ADRS).

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

State Agency--Case Management staff are employees of a state agency (ADRS).

Provider Qualifications

License *(specify):*

Professionals having earned a Master of Arts degree or a Master of Science degree, preferably in Rehabilitation counseling or related field, from an accredited college or university, or having earned a degree from an accredited School of Nursing. Transitional Case Management Services may be delivered by a SAIL employed possessing a BS degree in social work, psychology, or related field who has provided services an an Independent Living Specialist. Transitional Case Management Services will also be conducted by case managers who meet the minimum accredited college/university qualifications described above.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualifications is monitored annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

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):*

AIL Waiver Personal Care Services provide assistance with activities of daily living.

Personal care workers (PCWs) must meet State standards for this service. Personal care must be provided by an individual who is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

Personal Care services include:
a. Support for activities of daily living, e.g., provided to the recipient and not family members:
-bathing
-personal grooming
-personal hygiene
-meal planning and preparation
-assisting clients in and out of bed
-assisting with ambulation
b. Home Support that is essential to the health and welfare of the recipient, e.g.
-light cleaning
-light laundry
-home safety
c. Basic monitoring of the client, such as skin condition while bathing, excessive sweating, abnormal breathing, abnormal lethargy, and recognition of emergencies.
d. Medication monitoring, e.g., the type that would consist of informing the client that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the PCW is responsible for giving the medicine; however, it does not preclude the PCW from handing the medicine container to the client.
e. Under no circumstance should any type of skilled medical service be performed by the PCW.
f. Personal Care service is not an entitlement. It is based on the needs of the individual client.
g. Personal Care service should not be used for respite care.

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

The Unit of Service will be per 15 minute increments of direct PC service provided in the client's residence. The number of units authorized per visit must be stipulated on the PCCP and the Service Provider Contract. The amount of time authorized does not include provider transportation time to and from the client's residence.
(Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a participant's spouse, or to a minor by a parent or stepparent.)

The number of units and services provided to each participant is dependent upon the individuals need as set forth in the participants Plan of Care established by the Case Manager. Personal Care Services may be provided for a period not to exceed 100 units (25 hours) per week and/or not to exceed a total of 5,200 units (1300 hours) per waiver year in accordance with the provider contracting period. Individuals already receiving more than 100 units per week will continue to receive services based on their need as verified in the PCCP. (Services may also be reduced based on their need.) 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
Individual	Personal Choices- Self-Directed Workers
Agency	Home Care Agency or Home health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Personal Choices- Self-Directed Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employment verification checks (national background check, sex offender registry, List of Excluded Individuals and Entities, etc.) specific training is required from the individual's plan before working alone with the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS and the FMSA

Frequency of Verification:

Initially and Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Care Agency or Home health Agency

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Certificate of Need (CON) if the provider type is a Home Health Agency

Other Standard *(specify):*

Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Rehabilitation Services Certification Surveyor

Frequency of Verification:

Annually and Bi-annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Unskilled Respite

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

Respite Care is provided to participants unable to care for themselves and is furnished on a short-term basis because of the absence of or need for relief of those persons normally providing the care.

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

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

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

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

This service is limited to 300 hours/year and is dependent upon the individual participant's need as set forth in the participant's PCCP established by the Case Manager.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Care Worker- Unskilled

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Unskilled Respite

Provider Category:

Agency

Provider Type:

Respite Care Worker- Unskilled

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Certificate of Need if the provider is a Home Health Agency

Other Standard *(specify):*

Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Medical Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*

Medical supplies include devices, controls and/or appliances, specified in the PCCP, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary, and be specified in the PCCP.

Providers of this service will be those who have a signed provider agreement with the Department of Rehabilitation Services. The case manager must provide the participant with a choice of vendors in the local area of convenience. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

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

All waiver medical supplies must be prescribed by a physician, be medically necessary, and be specified in the PCCP. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation. Medical Supplies are limited to $2,400.00 per recipient per year. ADRS must maintain documentation of items purchased for the participant.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Waiver Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Medical Supplies

Provider Category:

Individual

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS Certification Surveyor

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology Repairs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service will provide for the repair of devices, equipment or products that were previously purchased for the participant through Assistive Technology waiver services. The repair may include fixing the equipment or devices, or replacement of

parts or batteries to support the equipment's continued operation. This service is necessary to ensure health and safety and prevent institutionalization. All items and services must meet applicable standards of manufacture, design and installation.

Provider Standards
The business providing these repairs will possess a business license. They will also be required to give a guarantee on work performed.

Repairs outside the warranty period will be reimbursed by ADRS.
The maximum amount for this service is $2,000.00 per participant annually. Record of repairs must be kept in the recipient's case record.

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

The maximum amount for this service is $2,000.00 per recipient annually. The repair total must not exceed the amount originally paid for the equipment or device. Failure by the provider to collect available third party payments may result in recoupment of these payments by ADRS.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendor with a business license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Repairs

Provider Category:

Individual

Provider Type:

Vendor with a business license

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Other Standard *(specify):*

Vendor is responsible for providing a guarantee on work performed

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Rehabilitation Services Certification Surveyor

Frequency of Verification:

Annually upon initial approval, biannually thereafter if no compliance concerns exist, or more often if needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation NET) Services have been exhausted. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities.
The service may also be provided to assist an individual to transition from an institutional setting to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric).

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

The amount for this service is $25,000.00 per waiver participant per lifetime. Any expenditure in excess of $25,000.00 must be approved by the state coordinator.
Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendor with a Business license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Vendor with a Business license

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Other Standard *(specify):*

Vendor is responsible for orientation to the equipment

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Manager

Frequency of Verification:

As needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations (EAA)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
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):*

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

Provider Qualifications
EAA will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor. If the contractor is not licensed, an ADRS employed Rehabilitation Technology Specialist to do a final inspection to ensure compatibility with local building code.

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

This service is necessary to prevent the institutionalization of the recipient. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Limits on EAA are $8,500 per waiver client for the entire stay on the waiver. Any expenditure in excess of $8,500 must be approved by the state coordinator.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Contractor. Unlicensed contractors will require a final inspection by a Rehabilitation Technology Specialist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (EAA)

Provider Category:

Individual

Provider Type:

Licensed Contractor. Unlicensed contractors will require a final inspection by a Rehabilitation Technology Specialist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

If the contractor is not licensed, an ADRS employed Rehabilitation Technology Specialist to do a final inspection to ensure compatibility with local building code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Rehabilitation Technology Specialist

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Evaluation for Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service will provide for an evaluation and determination of the client's need for Assistive Technology. The evaluation must be physician-prescribed and be provided by a therapist licensed to do business in the State of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS). This service is necessary to prevent institutionalization. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver.
Service includes complete participant assessments related to various physical skills and functional ability including neuro-muscular, coordination and control, balance and ambulation.

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

Reimbursement for this service will be the standard cost per evaluation as determined by Alabama Medicaid and ADRS.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Waiver Provider for ADRS and Medicaid

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Evaluation for Assistive Technology

Provider Category:

Individual

Provider Type:

Certified Waiver Provider for ADRS and Medicaid

Provider Qualifications

License *(specify):*

Physical Therapy License

Certificate *(specify):*

Other Standard *(specify):*

No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of Assistive Technology Devices.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS Certification surveyor

Frequency of Verification:

Annual the first year, bi-annual thereafter, unless concerns exist.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Assistive Technology

HCBS Taxonomy:

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

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable the participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

Minor Assistive Technology is necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition.

The service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. ADRS records on each participant must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
MAT/devices include those assistive aids necessary for the participant to perform or assist in performing activities of daily living skills, and in prevention and monitoring of medical condition.
MAT authorizations include, but are not limited to: shower chairs, specialized cushions, alternating pressure pad and pump, specialized mattresses, over the bed table, shampoo tray, reachers, lift sling, transfer board, glucometer, green boots, urinal, ADL cuff-holders, elbow protectors or pads, hand splints, and specialized feeding utensils or additional medical supplies to maintain health and safety. MAT/devices must be prescribed by a physician.
Items reimbursed with waiver funds shall be in addition to any MAT/devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

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

MAT does not include common over-the-counter personal care items. Items reimbursed with waiver funds shall be in addition to any medical supplies or devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. All items shall meet applicable standards of manufacture, design and installation. Minor Assistive Technology is limited to $500.00 per participant per year. ADRS must maintain documentation of items purchased for the participant.

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

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

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Waiver Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Assistive Technology

Provider Category:

Individual

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers will be those who have a signed provider agreement with the Alabama Department of Rehabilitation Services. Vendors providing MAT/devices should be capable of supplying and training in the use of minor assistive technology/device.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Assistance Service (PAS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

PAS are a range of services provided by one or more persons designed to assist an participant with a disability to perform daily activities on the job. These activities would be performed by the participant if that individual did not have a disability. Such services shall be designed to increase the participant's independence and ability to perform every day activities on the job. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those in competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting. This service will be sufficient to support the competitive employment of people with disabilities of at least 40 hours per month.

This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistants transportation time to or from the recipients home or place of employment. The PAS received by an individual will be based on the participant’s needs. The number of hours must be stipulated on the Plan of Care and Service Provider Contract. If this service is used for employment, ADRS is required to have a signed agreement with the employer stating that it is acceptable to have a PAS worker on the job site. PAS is required, but are not limited to assisting with: Outside Home/Job Site: Essential shopping, transportation to and from work, eating, toileting, medication monitoring, entering or exiting doors. Individual records will be maintained to document that each member of the staff has met the above requirements.

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

The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.

The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the participant’s home or place of employment.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Choices- Self-directed Workers
Agency	Home Care Agency or Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Service (PAS)

Provider Category:

Individual

Provider Type:

Personal Choices- Self-directed Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employment verification checks (national background, sex offender, List of Excluded Individuals and Entities, etc.) and specific training is required from the participant's plan before working alone with the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADRS and 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: Personal Assistance Service (PAS)

Provider Category:

Agency

Provider Type:

Home Care Agency or Home Health Agency

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Certificate of Need (CON) if the provider type is a Home Health Agency

Other Standard *(specify):*

Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Rehabilitation Services Certification Surveyor

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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 (Installation)

HCBS Taxonomy:

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

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable help button to allow for mobility. The system is connected to the persons phone and programmed to signal a response center once a help button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. The system is connected to the participant's phone and programmed to signal a response center once a help button is activated. By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

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

Price Quotation from the Vendor Providing the Service Specifying the Description of Personal Emergency Requested.

The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (Installation)

Provider Category:

Individual

Provider Type:

Business Vendor

Provider Qualifications

License *(specify):*

Business license

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

SAIL Waiver case manager.

Frequency of Verification:

As required.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (Monthly Fee)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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

The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendor with a business license.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (Monthly Fee)

Provider Category:

Individual

Provider Type:

Vendor with a business license.

Provider Qualifications

License *(specify):*

Vendor providing this service will possess a business license.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Case Manager

Frequency of Verification:

As needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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

Pest control services may be provided in a waiver participant's primary residence, which is limited to
a) a participant living in his/her own private house or apartment and who is responsible for his/her own rent or mortgage; or
b) a participant living with a primary caregiver.

Pest Control services include the following activities:
a) assessment or inspection
b) application of chemical-based pesticide
c) Follow up visit

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pest Control Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Service

Provider Category:

Agency

Provider Type:

Pest Control Company

Provider Qualifications

License *(specify):*

State of Alabama Business License
Licensed and Certified

Certificate *(specify):*

Other Standard *(specify):*

Code of Alabama, 1975, § 40-12-40
Possess licensure and certification approved through the Alabama Department of Agriculture and Industries.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Initially; then annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supervisory Visit

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring
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):*

Supervisory Visits are conducted by Alabama Licensed Registered Nurse or Alabama Licensed Practical Nurses to monitor DSP staff performance to ensure adherence of Waiver guidelines, quality of service provision to waiver recipients, and recipient satisfaction with service provision. Supervisory Visits shall be conducted by a Registered Nurse (RN) or Licensed Practical Nurse {LPN) who must meet all federal and state requirements to provide services to eligible Medicaid recipients under this waiver authority.

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

Supervisory Visits shall be billed in 15 minutes increments not to exceed 60 minutes or 4 increments every 60 days. No reimbursement will be made for attempted or missed visits. One increment is defined as 15 minutes. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.

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 Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supervisory Visit

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed by the Alabama Board of Nursing to practice nursing in the state of Alabama.

Certificate *(specify):*

Certificate of Need is required if the provider is a Home Health Agency

Other Standard *(specify):*

The workers must comply with AMA's policy for TB testing requirements. The employee must be an RN and undergo all training requirements. A minimum of twelve (12) hours of relevant in-service training per calendar year is also required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Rehabilitation Services

Frequency of Verification:

Nursing license shall be verified at initial hire and annually thereafter

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

National background checks are required for direct service provider employees who operate within the State of Alabama and who either provide direct services to the participant and/or who have access to participant records. The national background checks will be conducted by the provider agency and will also include a reference check with previous employers, sex offender registry, and the Nurse/Aid Registry. Verification of investigations will be conducted during audit reviews of the service providers by ADRS.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Only as described in Appendix E related to the 1915j

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that 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.

Services provided by relatives or friends may be covered only if relatives or friends meet the same qualifications as other direct care providers and are employed by an approved provider of service. Relatives who are providers of services cannot be a parent/guardian of a minor or spouse of the participant receiving services, when the services are those that these persons are legally obligated to provide.
There must be justification as to why the relative of friend is the provider of care and documentation in the case managers file showing the lack of other qualified providers.

The strict controls to assure that payment is made to relatives or friends as providers in return for authorized services include the following:
1) The relative or friend must be employed by a Direct Service Provider (DSP) Agency.
2) Meet the qualifications outlined in the scope of service as any other personal care, respite, homemaker, or companion worker employed by a DSP agency.
3) Complete a service log reflecting the type of service provided including the number of hours of service, the date and time of service.
4) Have the participant/or representative sign the service log at each visit. If the relative or friend normally acts as a representative another individual
must sign the service log.
5) The service log is reviewed by a DSP supervisor at least once biweekly.
6) Supervisory visits to the participants residence at 60 day intervals.
7) Direct on-site supervision of the DSP worker providing the authorized service at least once every 6 months and more frequently if warranted.
8) Monthly visits by the case managers to address participant satisfaction with the provision of services and to question the participant confidentially about the adequacy of the services
received and their needs are met as well as to observe the participant or friend as services are provided.

While each service may be offered by a relative the state will ensure that no conflict of interest will occur because the relative providing the direct service will not be involved in the development of the PCCP or allowed to sign service logs which serve as documentation that the authorized services have been provided when the participant is unable to do so. When the primary care giver or authorized representative for the participant must also act as the direct service provider worker another individual must be assigned the aforementioned responsibilities as well as assume responsibility for any other functions which could potentially result in a conflict of interest. The case manager must be available during the monthly visits to observe the provision of the direct service by the guardian and question the participant confidentially about their satisfaction with those services.

Personal Choices participants may hire legally liable relatives as paid providers of services. However, restrictions do apply on participant living arrangements, when homes or property are owed, operated or controlled by a provider of services, not related by blood or marriage to the participant.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared and mailed. Every new provider is also required to attend a waiver training conducted by ADRS.

When all information from the potential provider has been reviewed and verified, a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement of the SAIL Waiver based on ADRS's review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter.
The State does not have a specified timeframe for providers to become enrolled. The State works with potential providers by allowing them time to submit requested information, hire personnel, and assemble items needed to meet waiver requirements. When provider clears the initial phase, ADRS Audit Staff makes an on-site visit to perform a verification audit. When the provider clears this phase, ADRS enters into a contract and enrolls the provider. All willing and qualified providers are given an opportunity to enroll as a waiver provider.

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, and any applicable requirements of state laws prior to service provision. NUMERATOR [# of new contracted providers that met initial licensure and/or certification standards, other standards est. by AMA, etc.]/ DENOMINATOR[All new contracted providers]

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

	Specify:	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of existing contracted providers that continued to meet licensure and/or certification standards, other standards established by Medicaid and any applicable requirements of state law. NUMERATOR [Number of existing contracted providers that continued to meet licensure/certification standards and other standards established by AMA]/ DENOMINATOR [Number of existing contracted providers.]

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

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: 100% of provider training verification records are reviewed over a two year cycle	

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers who continue to meet

waiver provider qualifications. NUMERATOR: Number of non-licensed/non-certified providers who continue to meet waiver provider qualifications. DENOMINATOR: Number of non-licensed/non-certified waiver providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers who met initial waiver provider qualifications. NUMERATOR: Number of non-licensed/non-certified providers who met initial waiver provider qualifications. DENOMINATOR: Number of new non-licensed/non-certified waiver providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of self-directed employees/staff that meet state and waiver requirements. NUMERATOR [Number of self -directed employees that meet state and waiver requirements]/ DENOMINATOR [Number of self-directed employees/staff]

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMSA Employee Enrollment Packet

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

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percentage of providers that meet training requirements in accordance with state requirements and the approved waiver. NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver]/ DENOMINATOR [Number of providers]

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

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Initial Enrollment 100% of provider training verification records are reviewed over a two year cycle	

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. 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:

Performance Measure:
Number and percentage of new self-directed employees that meet waiver training requirements. NUMERATOR [Number and percentage of new self-directed employees that meet waiver training requirements]/ DENOMINATOR [Number of new 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.

Alabama Medicaid has granted the Alabama Department of Rehabilitation Services (ADRS)authority to determine the qualifications of providers. AMA annually reviews ADRS training documentation for compliance with state requirements. AMA conducts quarterly Quality Assurance meetings. These meetings are designed to inform, educate, discuss matters of concern, etc.

b. Methods for Remediation/Fixing Individual Problems

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

ADRS must investigate all high risk health and safety issues upon receipt of notification and initiate action within 24 hours. If necessary the recipient and/or DSP will be interviewed. ADRS must also notify Alabama Medicaid within two working days. ADRS and Alabama Medicaid will review the issue to determine if there is a pattern of problems and no health and safety risks exist. Alabama Medicaid will contact the client via telephone to ensure full resolution to the incident has been completed satisfactorily. Any final determinations including any DSP probations and or termination will be reported to the Alabama Medicaid.

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.

ADRS will ensure that all providers meet state requirments as outlined in the waiver by requiring each to submit the necessary certifications annually.

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.)*

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.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☐ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☐ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***
- ☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☐ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☐ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ◉ **No, the waiver does not include provider-owned or controlled settings.**
- ○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☐ **Each individual has privacy in their sleeping or living unit:**
    - ☐ **Units have entrance doors lockable by the individual.**
    - ☐ **Only appropriate staff have keys to unit entrance doors.**
    - ☐ **Individuals sharing units have a choice of roommates in that setting.**
    - ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☐ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☐ **Individuals have access to food at any time.**
  - ☐ **Individuals are able to have visitors of their choosing at any time.**
  - ☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Care Plan (PCCP)

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:

Case Management will be conducted by Case Managers who meet the minimum qualifications below:

A. Professionals having earned a Masters degree in counseling, or a Bachelor of Arts degree or a Bachelor of Science degree, preferably in human services or related field from an accredited college or university, or a degree from an accredited School of Nursing.

B. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by Alabama Medicaid and attend on-going training and in-service programs deemed appropriate. Initial orientation and training must be completed within the first three months of case manager employment. Proof of the training must be recorded in the Case Manager's personnel file. Case Management training must be completed prior to case managers being authorized to provide services. Any exception to this requirement must be approved by Alabama Medicaid.

C. ADRS will be responsible for providing a minimum of six hours relevant in-service training per calendar year for Case Managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year. Documentation of the training shall include: topic, name and title of trainer, training objectives, and outline content, length of training, list of trainees, location and training outcomes. Topics for specific in-service training may be mandated by Alabama Medicaid. Annual in-service training is in addition to the required orientation and training. Proof of training must be recorded in the personnel file. Person Centered Thinking Training from certified PCT Trainers (through The Learning Community for Person Centered Practices) is required for all Case Managers.

D. ADRS must have a Quality Assurance Program for case management services in place and approved by Alabama Medicaid. The Quality Assurance program shall include case manager record reviews at a minimum of every 90 days. Documentation of quality assurance reviews and corrective action plans must be maintained by ADRS and will be subject to review by Alabama Medicaid.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The ADRS Case Manager, the participant and/or a family of legal representative and/or other persons designated by the participant will all meet to develop the Person Centered Care Plan (PCCP). During the meeting all parties will discuss the needs and vision of the participant, informal supports provided by family or other community resources, and identify the gaps in supports. The Case Manager informs the participant of waiver services and other resources as part of the holistic approach to PCCP planning and development of holistic array of services and supports driven by participant preferences and support needs. The participant decides which personal representative will be involved in development of the plan of care. The PCCP development meeting is designed to increase the participant's self-determination and improve their own independence.

Developing a PCCP will include a comprehensive review of the participant's strengths and weaknesses. Based on identified needs, mutually agreed upon goals are set. This process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized.

Development of the PCCP for all individuals transitioning from the institution is based on individual needs. Development of the PCCP should include participation by the client, the individual's family/sponsor and Case Manager. This process will provide information for all individuals to make informed choices regarding available community services and support. During the transition period, special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed. Informal supports are crucial in supplementing the PCCP. Waiver services cannot be provided 24/7, therefore informal supports are used to ensure health and safety when waiver services are not in the home.

The PCCP development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources.

Service Coordination will be accomplished by the Case Manager along with input from the participant/family/caregiver, and other involved agencies/parties as needed. All services needed by the participant will be included in the PCCP implemented by the Case Manager.

Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The PCCP and service contracts will be updated to reflect any changes in service needs.

Monitoring - each case will be monitored monthly through phone contacts and at least one face-to-face visit monthly with the participant. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed. The PCCP must be reviewed every 60 days in the presence of the participant to make sure services are appropriate for participant's needs. In limited extenuating circumstances these may be completed by virtual or remote means as dictated by policy. Electronic signatures are permissible on waiver forms for service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The person-centered care plan is developed collaboratively with the participant, case manager, family or legal representative, and other persons designated by the participant. The PCCP is developed as a part of the initial assessment for all applicants for available waiver services and revised periodically as the needs of the participant change.

The case manager schedules a meeting with all interested parties to secure information about the participant's needs, preferences, goals, other non-waiver services or community supports. The case manager completes a needs assessment to assist with the development of the PCCP. The participant and/or their family member or legal representative are informed of services available through the waiver. Medical information obtained from the participant's physician is considered. The PCCP is then developed and is based upon the participant's functional capacity, limitations, health care needs, formal and informal supports from the family, caregiver(s) and community. PCCPs are individualized for each participant and seek to balance the participant's rights, values and preferences. During the home assessment/interview, the applicant and/or representative discuss their needs with the case manager. They come together to decide how to meet the needs and preferences. The plan is validated by monthly monitoring at home visits to ensure the desired outcomes are met. The home assessment/interview process discovers what the health care needs are and what services and resources are necessary through the SAIL waiver or other non- waiver resources. The case manager also keeps track of medications, doctor visits, etc. to their health care needs are met or to recommend or coordinate additional resources. The case manager monitors waiver and non-waiver services monthly and documents the progress/status of those services. By providing necessary coordination with providers of non-medical, non-waiver services, the case manager can ensure the participant is functioning at the highest attainable level or benefit from programs for which they may be eligible for.

When the PCCP is developed with the necessary waiver services, the participant is given a choice of qualified and willing providers of waiver services. The participant/and or their family or legal representative must complete a freedom of choice form to document that they were given a choice of qualified providers of waiver services. The amount, duration and frequency of all waiver services are documented in the PCCP to avoid duplication of services and to establish complete coordination of care. Services contained in the PCCP are those services the participant is willing to accept, for which the participant has a justifiable unmet need, and there is a qualified provider of direct services available to provide the designated services. The case manager completes a service authorization form which is forwarded to the direct service provider to ensure services are provided in accordance with the PCCP. After the PCCP is completed and implemented; it will be evaluated for its effectiveness. The time frame for this evaluation will depend on numerous factors and will vary but will always be completed at least annually corresponding with the participant's waiver eligibility dates.

The PCCP must be reviewed and initialed every 60 days by the case manager. During the 60-day review, the case manager will review the PCCP with the participant, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are written in by the case manager, to be later updated. A copy of the PCCP remains in the participant's home. Services may be initiated or changed at any time within a contract period to accommodate a participant's changing needs. Any change in waivered services necessitates a revision of the PCCP. When a PCCP is revised, as warranted by changes in the participant's condition, the participant/and or their family member or legal representative must be issued a written notice at least ten days prior to any adverse actions that may result from the change.

Types of assessments that are conducted as part of the PCCP development process:
The ADRS case manager begins with a screening and evaluation process for each applicant. This includes learning about the medical condition and history as well as obtaining the demographic information and learning about the home and community environment. Next ADRS performs a Pre-Admission review, which begins the development of the PCCP. Once ADRS determines if the applicant eligible for the SAIL waiver a home assessment and detailed interview is performed. This is where the case manager learns and documents the participant strengths, capacities, needs, etc. and how the SAIL waiver can meet and assist with those needs. The PCCP encompasses a comprehensive review of the participant’s problems and strengths. Based on identified needs, mutually agreed upon goals are set. The PCCP development includes participation by the participant and/or family/primary caregiver, and case manager. The PCCP development process involves all persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

a. Once a referral is received, the Case Manager makes a face-to-face visit with the participant for evaluation and completion of the Home and Community-Based Services (HCBS) application. To clarify the assessment information,

the Case Manager may consult with the participant and caregiver as applicable, and physician regarding the medical,behavioral, functional, and social information and needs.

Once the Case Manager has collected information during the assessment process, a Person-Centered Care Plan (PCCP) is completed. The PCCP encompasses a comprehensive review of the participant's needs and strengths. Based on identified needs, mutually agreed upon goals are set. The PCCP development should include participation by the participant and/or family/primary caregiver, and Case Manager. The PCCP development process provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized. All waiver and non-waiver services are included in the PCCP. The amount, frequency and beginning date of service depend on the participant's needs.

b. The HCBS application is reviewed by a Registered Nurse at ADRS' state office for appropriateness of waiver admission. Justification for level of care determination must be properly documented in the participant's file.

The Case Manager must submit a Service Authorization to the Direct Service Provider (DSP) Agency authorizing waiver service(s) and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the participant's needs as set forth in the PCCP.

c. An initial visit is required before a DSP begins to provide services to a participant in the participant's place of residence. If a participant receives more than one service from the same direct service provider, only one initial visit is required. If a participant has more than one DSP, an initial visit shall be conducted with each DSP. The initial visit shall include, at a minimum, the Case Manager, the DSP Supervisor, the DSP Worker, the participant and caregiver, as applicable.

d. The PCCP is developed according to needs identified during the assessment process in collaboration with identified medical needs addressed by the physician. Each case will be monitored monthly through phone contacts and at least one face-to-face visit with the participant. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were received. Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing participants according to medical conditions that are unstable, participants who require extensive care, and/or participants who have limited support systems.

e. The Case Manager will identify other community and state plan services a participant may need and incorporate those services and needs with input from the participant and/or responsible relatives shall be instructed to notify the Case Manager if services are not provided as planned, or if the participants condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the PCCP. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Person Centered Care Plan and service authorizations will be updated to reflect any changes in service needs.

g. The case managers review the PCCP in the presence of the participant at least every 60 days and update the PCCP at least annually and when there is a change in the participant's needs. Services may be initiated or changed at any time within an authorization period to accommodate a participant's needs. Any change in waiver services necessitates a revision of the PCCP. The revised PCCP must coincide with the narrative explaining the change and a new Service Authorization Form should be submitted by the Case Manager to the DSP.

If the DSP identifies additional duties that would be beneficial to the participant's care, but are not specified on the PCCP, the DSP will contact the Case Manager to discuss having these duties added.

(a) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(b) The Case Manager will approve any modification of duties to be performed by the waiver service worker and re-issue the Service Authorization Form accordingly.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to participant's safety are identified and mitigation strategies are documented in the PCCP. Plans are individualized and take into consideration participant's rights, values, and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit the participant's health and welfare is reviewed, the PCCP is adjusted accordingly and evaluated for appropriateness. Also during the monthly visit, the case manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the PCCP. The case manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered to have a potential risk the case manager may visit more often than monthly to monitor the situation to ensure the participant's health and safety is not jeopardized. When a risk has been reported or identified, a home visit to monitor the health and safety of the participant is required as soon as it can be arranged. Case managers will review and modify the PCCP if necessary to address the concerns.

Additionally, Direct Service Provider (DSP) staff must visit the participant's home as ordered on the PCCP. DSPs are trained and expected to observe and report any concerns about a participant's health and welfare to the case manager and in writing to the supervisor at the DSP agency. DSP have policies and procedures established for serving participants in the event the assigned worker is unable to provide the service. As part of this back-up protocol, the DSPs are notified of participants who may be a potential risk so that the case manager will be able to give them first priority when service visits must be temporarily prioritized and/or reduced by the DSP.

Waiver participants are also informed of procedures necessary to file a formal complaint or grievance regarding availability or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility.

The case manager, participant, and/or representative discuss all identified risks. Prior to initiating a service authorization, the case manager must contact the provider to determine the start date and discuss any special needs of the participant. Identification is required of the participant whose needs are such that the absence of an authorized waiver service would have a substantial impact on the participant’s health and safety. In cases where the participant is determined to be at risk for missed visits, the authorization will be flagged when initiated. If the at-risk status changes, the existing authorization is revised and sent to the provider indicating the current status.

The case manager, participant and/or representative must develop an Emergency Disaster Plan. The emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a participant who would be vulnerable during the emergency/disaster:

(1) Not Priority - Participant is not vulnerable during emergency/disaster or has adequate supports to meet his or her needs. (Example: Participant with functional deficits, but family willing and able to evacuate and/or meet needs.)

(2) Priority, Participant Lives Alone - Participant lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Participant lives alone and has no one available to evacuate him or her or has no one to give insulin.)

(3) Priority, Advanced Medical Need - Participant has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Participant is on ventilator, dialysis, or other specialized equipment/service.)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As the PCCP is developed, the case manager discusses and documents the participant’s freedom to choose a direct service provider (DSP) from the list of approved contract providers that are qualified, available, and willing to provide the services. The case manager presents a list of all qualified providers listed in alphabetical order for all waiver services available in the area. The list includes the services the DSP is approved to provide and the hours the DSP is available to provide those services. The participant then ranks the providers by choice with a minimum of three providers chosen, or more if the participant selects additional providers. A written choice should be made for each waiver service that the participant desires to access. The freedom of choice provider list form is kept in the participant's record to serve as evidence of individual choice. The participant can change providers at any time by notifying the case manager. Each month the case manager discusses freedom of choice of service providers with the participant to ensure proper delivery of services and participant's choice.

The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the participant is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The reason for the absence of a signed choice should be well documented in the case record.

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):

A person-centered care plan (PCCP) is developed for all waiver participants. The participant, the participant's family/sponsor and the Case Manager shall be involved in development of the PCCP. The case manager provides information for all participants to make informed choices regarding available community services and support. Special emphasis is put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed. Informal supports are crucial in supplementing the PCCP. Waiver services cannot be provided 24/7, therefore informal supports are used to ensure health and safety when waiver services are not in the home.

The PCCP development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources. Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The PCCP and service contracts will be updated to reflect any changes in service needs.

On an annual basis, Alabama Medicaid conducts a random sample audit at the 90% confidence level with a margin of error of +/- 10% of PCCP for persons receiving waiver services. The random sample of participants is chosen using a monthly report of enrollment data. The sample size of PCCPs for each quarter may vary, depending on these enrollment data, but will reach the 90% confidence level overall for each year .The purpose of this review is to ensure compliance with both state and federal guidelines, that clients receiving services under the waiver have a PCCP in effect for the period of time that the services were provided, and that services provided are documented as outlined in the PCCP.

If discrepancies relating to the PCCPs or compliance with other state and federal guidelines related to service delivery are identified during either the review, ADRS is notified in writing and is given the opportunity to resolve or clarify the discrepancies or provide a plan of correction. Results of the audit may result in recoupment of Medicaid funds.

ADRS conducts audits on a random sample of case management records at the 95% confidence level with a margin of error of +/- 5% to review PCCP and the quality of service delivery for persons receiving waiver services. If discrepancies relating to the PCCPs, quality of service delivery, or noncompliance with other state and federal guidelines related to service delivery are identified during either the review, the audited case manager is notified in writing and is given the opportunity to resolve or clarify the discrepancies or provide a Corrective Action Plan (CAP). The audit may result in recoupment of Medicaid funds.

Quarterly, Alabama Medicaid and ADRS meet to review case management issues, program administration, and to discuss operation issues.

ADRS must submit the person-centered plan procedures and format to Alabama Medicaid for review and approval. All person-centered plans must be completed using the approved procedures and format. The Appendix D performance measures are then used to evaluate various aspects of the implementation of the approved person-centered plan procedures and format. Appendix D performance indicators are based on a sample size in accordance with the 95% confidence interval with a +/- 5% margin of error. These performance indicator data are derived from audit processes of ADRS as indicated in the waiver application. However, for purposes of a secondary validation, Alabama Medicaid also completes an oversight audit of ADRS's work in this area, which is based on a sample size in accordance with the 90% confidence interval with a +/- 10% margin of error. These two levels of review provide ample data to confirm the person-centered plans are completed in the manner approved by Alabama Medicaid.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The entity responsible for monitoring the implementation of the person-centered care plan (PCCP) and participant health and welfare is the case management staff of ADRS. The PCCP is monitored and reassessed by ADRS case manager at least once a month during the face to face visit. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were identified by the participant to help achieve goals. The PCCP must be reviewed every 60 days in the presence of the participant to ensure services are appropriate for the participant's needs. Participants and/or responsible relatives shall be instructed to notify the case manager if services are not initiated as planned, or if the participant's condition changes. However, it is the responsibility of the case manager to promptly identify and implement needed changes in the PCCP. ADRS SAIL Waiver Program Management also conducts random home visits to monitor PCCP implementation and assess the health and welfare of participants.

When a participant has been approved for SAIL waiver services and the PCCP implemented, or when changes are made to the PCCP, the case manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services included in the plan. The case manager must ensure that waiver services requested on the service authorization include only those services contained in the approved PCCP. The DSP must receive documentation regarding the specific needs and desires of the participant and the specific tasks to be performed. Information included on the service authorization must be clear, specific, accurate and include the number of units or hours of service per day and the number of days per week which are authorized. DSPs are trained and expected to observe and report any concerns in a participant's health and welfare to the case manager and in writing to the supervisor of the DSP agency. The supervisor of the DSP agency has a responsibility to contact case management staff immediately by telephone when services cannot be provided to a participant determined to be at risk.

The case manager documents if the participant is satisfied with their choice of provider on a monthly basis. The case manager also rectifies any issues between the provider and participant. He/she also reminds the participant that they may choose another provider at any time

During the case manager’s monthly visit he/she will ask and document if the back-up provider was used. If so, the case manager discusses and documents if the plan was successful or needs to be revised to meet the participants’ needs. The case manager and participant and/or caregiver discuss non-waiver services during the monthly visit. The case manager documents the status and value of those services. He/she may also recommend additional non-waiver services that the participant may want or need. The case manager serves as a liaison for identified problems. They step in to find solutions and results to the problems. The follow-up method depends on the situation and takes more time and coordination than the regularly monthly visit.

The DSP Agency supervisor has a responsibility to contact case management staff immediately by telephone when services cannot be provided to a participant whose health and safety may be at risk if services are not provided as outlined in the PCCP.

Annual desk reviews are performed by Alabama Medicaid and include case management personnel files, participant files, and visits to participants in their homes.

Alabama Medicaid is informed by ADRS when there is a problem with a PCCP. Notification of critical situations is sent to Medicaid via "Critical Events/Incidents" forms. Less critical situations are sent to Medicaid via patient completed survey as well as discussion during home visits by the case manager. Data is evaluated for any type of trend in a PCCP. Negative trends could potentially be addressed by updating the service plan, reevaluating the DSP, or updating primary caregivers and their information. Rectifying problems with a participant's PCCP will be on an individual basis considering the participant's health and safety needs.

b. Monitoring 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 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 participantsï?½ 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. NUMERATOR [Number of participant service plans that address all participant's assessed needs, including health and safety risk factors]

DENOMINATOR: [Number of participant service plans reviewed]

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

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

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

Performance Measure:
Number and percent of participant service plans that address all participant's assessed needs, including health and safety risk factors. NUMERATOR [Number of participant service plans that address all participant's assessed needs, including health and safety risk factors]/ DENOMINATOR[Number of participant service plans reviewed]

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% confidence level with a +/- 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

c. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose needs changed and whose service plans were revised accordingly. NUMERATOR [Number of participants reviewed whose needs changed and whose service plans were revised accordingly]/ DENOMINATOR [Number of participants reviewed whose needs changed]

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

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 participants reviewed whose service plans are updated at least annually. NUMERATOR [Number of participants reviewed whose service plans were updated at least annually] DENOMINATOR [Number of participants reviewed]

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

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 PCCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver. NUMERATOR [Number of PCCP's reviewed that include the required participant signature in the PCCP development process]/ DENOMINATOR [Number of plans reviewed]

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

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 participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver. NUMERATOR [Number of participants reviewed whose service plans were reviewed with the participant according to the timeframes specified in the waiver]/ DENOMINATOR[Number of participants reviewed]

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

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:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver individuals that receive services and supports in the amount specified in the service plan. NUMERATOR [Number of waiver individuals that receive services and supports in the amount specified in the service plan] / DENOMINATOR [Number of participants reviewed]

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

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 individuals that receive services and supports in the frequency specified in the service plan NUMERATOR [Number of waiver individuals that receive services and supports in the scope/frequency specified in the service plan] / DENOMINATOR [Number of participants reviewed]

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% 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 individuals that receive services and supports in the type specified in the service plan. NUMERATOR [Number of waiver individuals that receive services and supports in the type specified in the service plan] / DENOMINATOR [Number of participants reviewed]

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

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 individuals that receive services and supports in the duration specified in the service plan. NUMERATOR [Number of waiver individuals that receive services and supports in the duration specified in the service plan] / DENOMINATOR [Number of participants reviewed]

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

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. NUMERATOR [Number of waiver participants reviewed that receive services and supports in the scope specified in the service plan]/ DENOMINATOR [Number of participants reviewed]

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

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 participants interviewed who reported the receipt of all services in the service plan. NUMERATOR [Number of participants interviewed who reported the receipt of all services in the service plan]/ DENOMINATOR [Number of participants interviewed]

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

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 and percent of participant records reviewed has a signed freedom of choice form that specifies choice was offered among waiver services and providers. NUMERATOR: Number of Participant records reviewed with a signed freedom of choice form. DENOMINATOR: Total number of participant record.

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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **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 interviewed that answered "yes, all services" to being able to choose or change what kind of services they received. NUMERATOR [Number of participants interviewed that answered "yes, all services" to being able to choose or change what kind of services they received]/ DENOMINATOR [Number of participants interviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant interviews

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. 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):
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% confidence interval 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 & percent of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services and institutional care. 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):
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% confidence interval with a margin of error of +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Alabama Medicaid Agency (AMA) has granted ADRS the authority to develop PCCP's. Alabama Medicaid will conduct retrospective record reviews on a quarterly basis. Alabama Medicaid will also review a percentage of case management records on a quarterly basis.

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.

Alabama Medicaid has developed a Quality Management Strategy for the SAIL Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing quarterly data to monitor appropriateness of level of care determinations; (2) Collect data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved (e.g., ADRS, DSP) to submit a

plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take

advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Personal Choices Program will be offered to participants to afford them the opportunity to direct and manage their own services to the extent they are able. If they are unable they may appoint a representative to act on their behalf. The following processes describe the provisions of this program:

Where the PCCP indicates the need for Personal Care services, Personal Assistance, or Unskilled Respite, each participant will be provided a choice between the traditional vendor or the Personal Choices option. The participant will share employer authority for the services they choose to self-direct. During the planning process, services and supports will be identified to meet the participant's individual needs and may include state plan services and natural support networks in addition to waiver services. At the time of the planning process, the SAIL Waiver Personal Choices Counselor will ensure that the participant and caregiver have sufficient information available to make informed choices about participation in the Personal Choices Program. The SAIL Waiver Personal Choices Counselor will also ensure that the participant has the information needed to make informed selections of qualified waiver providers and notify participants about their ability to change providers if they are not satisfied with a provider’s performance.

Personal Choices Program providers must not engage in any practices of registered nurses, certified registered nurse practitioners, or certified nurse midwife in accordance with the Alabama Nurse Practices' Act.

Participants who choose to self-direct personal care services will be referred to a Financial Management Service Agency (FMSA) that will function as an intermediary between each participant and individuals who perform the self-directed services. The FMSA will assist the participant and/or representative to facilitate employment of direct service providers. The FMSA will conduct the following tasks:
-Develop an enrollment packet for individuals that will provide personal care services;
-Perform background checks on prospective individuals who will provide personal care services;
-Provide information and training materials to assist in employment and training of workers;
-Facilitate meetings with the participant and the individual providing services;
-Manage and monitor on a monthly basis, all invoices from individual employees who provide waiver services against the amount of services authorized in a particular Person Centered Care Plan;
-Develop fiscal accounting and expenditures reports;
-Report problems regarding participant directed services to the SAIL Waiver Personal Choices Counselor;
-Work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's employees;
-Withhold federal, state, and local tax payments including FICA;
-File the necessary tax forms for the IRS and the State of Alabama;
-Provide the individual with the necessary tax information on a timely basis;
-File and withhold state unemployment insurance tax; and
-Make payments for invoices submitted by individuals or agencies providing personal care services.

The Personal Choices Counselor will monitor the provision of participant-directed services through monthly home visits to ensure services are delivered and health and safety is not compromised. The Personal Choices Counselor will also review invoices for accuracy prior to vendor payment. The FMSA will be monitored at least every two years by ADRS by audit staff.
La-Develop fiscal accounting and expenditures reports;
-Report problems regarding participant directed services to the SAIL Waiver Personal Choices Counselor;
-Work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's employees;
-Withhold federal, state, and local tax payments including FICA;
-File the necessary tax forms for the IRS and the State of Alabama;
-Provide the individual with the necessary tax information on a timely basis;
-File and withhold state unemployment insurance tax; and
-Make payments for invoices submitted by individuals or agencies providing personal care services.

The SAIL Waiver Personal Choices Counselor will conduct an initial orientation that begins with a self-assessment process using the Waiver Consumer Choices Roles and Responsibilities tool which provides a detailed description of the roles and responsibilities and support functions of the SAIL Waiver Personal Choices Counselor and the FMSA.

The Personal Choices Program participant may choose to manage their own personal support plans, or may appoint a

representative to assist them. All participants have an option of choosing one individual to act as a representative to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The SAIL Waiver Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Personal Choices Program participants will be allowed to direct services. Self-directed services are covered under the 1915(j) authority. Participants may choose to manage their own services or may appoint a representative to assist them. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services. Those who choose not to direct services will continue to receive their services through the traditional Waiver program.

The participant who elects to participate in Personal Choices is expected to be able to manage their own personal supports and other requirements of the program. However, if the participant's choice is to select a representative to assist in some or all of their Personal Choices decision-making and management responsibilities, the participant may do so. The counselor will provide training and assistance to the participant as requested to facilitate the choice between utilizing a representative and self-managing. The participant may also elect to use friends or others to provide assistance or help without designating a representative, but these individuals cannot sign documents, speak for, or otherwise act on behalf of the participant.

Participants who elect to self-manage but run into difficulty will be supported by the ADRS Personal Choices Counselor to resolve issues and identify methods by which the participant can continue to manage his/her own care. However, a representative may be required for continued enrollment if efforts at resolution fail to correct the issues. A representative can be a friend, caregiver, family member, or other trusted person. Representation may be required if a participant has a legally recognized, court-appointed representative or legal guardian. However, the participant may still be supported to participate in Personal Choices decision-making and management to the extent he/she wishes to do so. A designated representative must:
Show a strong personal commitment to the participant Show knowledge about the participant's preferences
Be willing and able to meet all program requirements listed of the participant Be at least 18 years old,
Be willing to submit to national criminal background checks,
NOT be known to abuse drugs or alcohol,
NOT have any history of physical, mental or financial abuse.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The SAIL Waiver Personal Choices Counselor will conduct an initial orientation that begins with a self assessment process using the Waiver Consumer Choices Roles and Responsibilities tool. This tool provides a detailed description of the roles and responsibilities of the participant including a detailed description of the roles, responsibilities and support functions of the SAIL Waiver Personal Choices Counselor and the FMSA agency. The participant and/or responsible party signs a Personal Choices rights and responsibilities document and receives a detailed manual. This document and manual describes the potential risks and liabilities. It also informs them of their choice to withdraw at any time.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants may choose to manage their own personal support plans or may appoint a representative to assist them. All participants have the option of choosing one individual to act as representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds.

The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The SAIL Waiver Personal Choices counselor will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care	☒	☒
Unskilled Respite	☒	☒
Personal Assistance Service (PAS)	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The FMSA contracts with the Operating Agency and was selected based upon the State of Alabama's procurement guidelines. The FMSA agency will enroll with ADRS as a provider. The FMSA will not provide any direct services. The FMSA operates as a Vendor Fiscal/Employer Agent. The FMSA contractor provides services in withholding, filing and paying federal and state income tax withholding, FICA, FUTA and SUTA in accordance with federal IRS and DOL and State of Alabama Departments of Revenue and Industrial Relations rules and regulations. The FMSA conducts required criminal background checks for all prospective employees of the Personal Choices Program. The FMSA performs all FMSA tasks directly and may not delegate any FMSA tasks to a third party without expressed written permission from the Operating Agency.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMSA will be paid on a monthly basis for activities set forth in the contract with ADRS.

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 activities will include bookkeeping services for the participant. The FMSA, as the employer agent, will assist participants to pay their employees and assure compliance with state and federal labor and tax laws. The FMSA activities will include a method of receiving funds from the state and making the funds available for the participant's budgets.

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.

ADRS will monitor the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours. Remediation of the problem will be expected within 48 hours of the FMSA being notified by the operating agency.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The SAIL Personal Choices Counselor and Waiver Case Manager will play a significant role in the overall development of the participant's personal support plan. The Case Manager will continue to assess supports and needs as well as health and safety risks as required by SAIL Waiver protocols. The Case Manager will perform re-assessment of the participant's level of care needs at least annually or as required by a change in condition in order to resolve any identified health and safety issues.

The State does not compensate entities for furnishing information. Assistance and information is received from either the FMSA, ADRS, or Alabama Medicaid. The Personal Choices program will provide participant protections to include: information to participants, participant training and skills assessment, counseling services, financial management services, development of emergency Back-up plans, development of an incident reporting system and access to program staff. Participants are required to use counseling and financial management services in order to assume responsibility for their care and financial management. The Counselor will train, coach, and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget to effectively meet their care needs, avoid overspending as well as prevent the under-utilization of their allocated budget. The FMSA, as the employer agent, will assist participants to pay their employees and assure compliance with state and federal labor and tax laws. The FMSA will provide a method of receiving funds from the state and making the funds available for the participants' budgets.

☐ **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
Assistive Technology	☐
Case Management	☐
Pest Control Service	☐
Personal Emergency Response System (Monthly Fee)	☐
Environmental Accessibility Adaptations (EAA)	☐
Personal Care	☐
Medical Supplies	☐
Supervisory Visit	☐
Unskilled Respite	☐
Assistive Technology Repairs	☐
Personal Assistance Service (PAS)	☐
Minor Assistive Technology	☐
Evaluation for Assistive Technology	☐
Personal Emergency Response System (Installation)	☐

☒ **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 SAIL Waiver Personal Choices counselor will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial assessment process, during reviews and updates to the Person Centered Care Plan. If the individual elects to direct their own services, they will be referred to the FMSA to provide employer related services. These include:
- Identifying and recruiting individuals or agencies that can provide personal care services;
- Developing an enrollment packet for individuals or agencies that will provide personal care services;
- Performing background checks on prospective individuals who will provide personal care services;
- Providing information and training materials to assist in employment and training of workers;
- Facilitating meetings with the participant and the individual or agency providing personal care services;
- Managing, on a monthly basis, all invoices for personal care services authorized in the participants' Person Centered Care Plan;
- Developing fiscal accounting and expenditure reports.

The methods and frequency of the FMSA review will be as follows:
- The FMSA will provide monthly reports to ADRS
- ADRS will perform on-site administrative and operational reviews
- ADRS will monitor the FMSA at least every two years by ADRS by audit staff.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A program participant may elect to discontinue participation in the Personal Choices Program at any time. Alabama Medicaid and ADRS will initiate procedures to serve as safeguards to ensure that the reasons for discontinuance are not related to abuse, neglect or similar concerns. It is the responsibility of the participant to initiate voluntary discontinuance by notifying the Counselor of such decision by phone, mail, or e-mail. The Counselor will document in the participant's record, the date of notification by the participant of their decision to discontinue in the Personal Options Program. The Counselor will begin the process within 5 business days from the date of notification.

A face-to-face contact is required to discuss the following:
-To provide an opportunity for the Case Manager to determine if the participant's health, and welfare has been jeopardized during the process
-To identify and resolve any problems that would enable continued participation with the program or confirm that the reasons for discontinuation cannot be resolved.
-To obtain the signature of the participant to attest to his desire to discontinue participation
-To explain the processes and timeline for return to the traditional service delivery option
-To ascertain the participant's choice of direct service provider

From the receipt of the participant's request to discontinue their participation, the timeline for initiation of traditional waiver services may be from 15 to 30 days. The Counselor will have 5 days to begin the process of reinstating traditional waiver services working closely with the Case Manager of the 1915(c) Waiver to facilitate continuity of care. Personal Choices Program services under the 1915(j) will continue until traditional services under the 1915(c) Waiver have been reinstated.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

ADRS may, if appropriate, discontinue the participant's choice to direct their services when, in the case manager's professional judgment through observation and documentation, it is not in the best interest of the participant to participant-direct their services. The SAIL Leadership Team will review documented observations of compromised health, safety, and well-being of the participant and documented attempted remediation (if appropriate). There must be concurrence to remove participant-direction and the participant will be returned to receiving traditional waiver services under the 1915(c).

Participants will be given advance notice in writing of their return to the traditional SAIL Waiver program. Although the decision to involuntarily disenroll the participant from the Personal Options Program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on the appeal. The participant/representative has 15 days from the date of the notification of their return to the traditional waiver program to request an informal review of the decision to disenroll the participant from the Personal Program. Alabama Medicaid will make a decision within 30 days from receipt of the request for an informal review.

If the informal review decision is unfavorable, the participant may appeal the decision within 60 days from the date of the written decision of their return to the traditional SAIL Waiver program in accordance with established Medicaid Fair Hearings provisions.

SAIL Waiver participants may be involuntarily returned to traditional waiver services for the following reasons:

-Health, Safety and Well-Being: At any time that the SAIL Waiver Personal Choices Counselor, Case Manager or Alabama Medicaid determines that the health, safety and well-being of the participant is compromised or threatened by continued participation in the Personal Choices Program, the participant will be returned to traditional waiver services.

-Change in Condition: If the participant's ability to direct their own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the participant will be returned to traditional waiver services.

-Under Utilization of Budget Allocation: The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is under utilizing the monthly allocation or is not using the allocation according to their personal support plans, the FMSA and Personal Choices Counselor will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under- utilization of the budget allocation, the participant will be returned to traditional waiver services.

-Failure to Provide Required Documentation: If a program participant/representative fails to provide required documentation of expenditure and related items as prescribed in the Waiver Consumer Choices Roles and Responsibilities tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the participant will be disenrolled from the program. The participant will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the Personal Choices Program.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		200
Year 2		215

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3		225
Year 4		240
Year 5		265

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost of conducting criminal background checks will be compensated as part of the payment to the FMSA.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

The SAIL Personal Choices Counselor will assist the participant with their budget. A potential person-centered care plan is discussed using current waiver services. An estimate of the total cost of that person-centered care plan will be used as the budget for a Personal Choices participant. The participant can arrange their services in a manner that's consistent with their health and safety needs. The participant can not exceed the budget amount that was agreed upon in the person-centered plan, without prior approval. The Counselor will provide the participant with the information regarding how to request an adjustment to their budget. Participants are made aware of their appeal rights upon admission to the SAIL Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The State assures that the methodology used to establish budgets will meet the following criteria:
A. Each recipients budget will be established based on the current hours of traditional personal care hours received each week. Of the total monthly amount, 10-15% will be directed to the FMSA for administration of the participant-directed personal care services. No other services will be available through this option. The primary choice for the recipient will be the decision regarding who will provide their personal care services.
B. The number of hours that a recipient will receive is based on the individual assessment of need and will remain unchanged, unless the participant need changes. All changes will be indicated on the waiver participant's PCCP. Each participant will be provided a form which will assist in determining the payment methodology and rate of pay for the personal care worker.
C. Services are reviewed for appropriateness monthly during the case management home visit. Any additional factors identified during the home visit or by other means are based on the assessment of need and will be indicated on the participant's PCCP. The Case Manager will notify the Personal Choices Counselor of any PCCP changes to remain consistent with the person centered budget.
D. Policy and procedures will describe the formula used to establish each participant's budget which will be applied consistently for each recipient who chooses the participant-directed option.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The State informs each participant of the amount of their monthly budget and the procedures by which to request an adjustment in the budget amount during the development of the personal support plans. Separate orientations to participant direction are provided by the SAIL Waiver Case Manager during the home visits. As a result, the potential participants are provided timely information about participant direction to allow them to make an informed decision about whether to enroll in the Personal Choices Options Program. For example, potential participants will be informed about the benefits and responsibilities associated with enrollment into the Personal Choices Options Programs.

Participants are made aware of their appeal rights upon admission to the SAIL Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The financial management activities will include:
-Identification of problems associated with the monthly allowance such as misuse or under-utilization of the funds;
-Participants/representative's failure to pay staff as required;
-Participant/representative's failure to comply with applicable state and federal laws;
-Participant/representative's failure to submit documentation of expenditures;

Theft of checks mailed to participants or other problems will be reported in writing to Alabama Medicaid and ADRS.

The SAIL Personal Choices Counselor will train, coach and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget effectively to meet their care needs, avoid overspending as well as to prevent the under utilization of their allocated budget.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As part of the assessment and service coordination visit, participants and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions.
Service coordination also includes an exploration of all resources currently utilized by the participant, both formal and informal, as well as those waiver services that may be provided to meet the participants' needs. If any needs cannot be met, these also are discussed with the participant and his family to fully inform them of the alternatives.

Description of the States procedures for allowing individuals to choose either institutional or home and community-based services:

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the participant changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the form and has no legal or responsible party who can sign. In such a situation, services will not be denied just because a written choice statement cannot be obtained. The Personal Choices Counselor or case manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

Description of how the individual (or legal representative) is offered the opportunity to request a Fair Hearing:

1. If a participant chooses to appeal the decision, a written request must be submitted to the contact person designated by ADRS within 30 days from the date of the notice of action. However, services may continue until the final outcome of the hearing, if the written request is received within 10 days after the effective date of the action.

2. ADRS will schedule the Informal Conference, notify the participant by certified mail, and contact the Medicaid Waiver Program Administrator to get the names of the Alabama Medicaid staff that will be attending the conference. The Informal Conference should be scheduled within seven business days of receiving the hearing request.

3. ADRS will forward a hard copy of the Informal Conference notification letter to the Medicaid Waiver Program Administrator with the date, time, and place of the Informal Conference or a conference call number, if listed.

4. If necessary, ADRS and the Medicaid Waiver Program Administrator may schedule a pre-conference meeting to discuss any pertinent information. This meeting may be face-to-face or by phone.

5. After the Informal Conference, Alabama Medicaid will review the documentation presented during the Informal Conference with ADRS staff. ADRS and Medicaid Nurse Reviewer will submit their recommendations in writing to the Medicaid Waiver Program Administrator.

6. The Medicaid Waiver Program Administrator will send a certified letter notifying the participant of the decision. A copy of the letter will be sent to ADRS, nurse reviewer, and others as specified.

7. If the participant/guardian is still dissatisfied after the Informal Conference, a Fair Hearing may be requested. A written request for a hearing must be received no later than 30 days from the date of the notice of action. (letter notifying participant of the Informal Conference outcome).

FAIR HEARING PROCESS

1. When the appropriate Medicaid Waiver Program Administrator receives a written request for a Fair Hearing, the date-stamped envelope will be retained, an entry made in a waiver log, a record established, and a copy of the written request will be faxed to the ADRS and the AMA's Office of General Counsel.
Note: If the request for a Fair Hearing is received by the ADRS or the AMA Office of General Counsel, a copy of the written request will be faxed to the appropriate Medicaid Waiver Program Administrator.

2. ADRS will develop a summary packet which will include a full summary, denial notice, and all other pertinent documents related to the action with which the participant/guardian is dissatisfied.

3. Once the summary packet has been prepared, the Alabama Medicaid Office of General Counsel will create a Scheduling Request to be sent to the Administrative Law Judge (ALJ) and copied to the primary witnesses.

4. 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 participant/guardian, ADRS, and Alabama Medicaid. ADRS Office of General Counsel will be responsible to prepare and conduct the hearings and the Alabama Medicaid will maintain the responsibility of coordinating and scheduling the hearings, to include the scheduling and coordinating of the ALJ.

5. Once the hearing has been held, the ALJ will make a recommendation and send a copy of the recommendation to the participant/guardian, ADRS, and Alabama Medicaid.

6. ADRS may provide comments on the recommendation to the Alabama Medicaid Office of General Counsel. After reviewing the recommendations, a concurrence/non- concurrence letter will be signed by the Alabama Medicaid Commissioner and mailed to the participant/guardian, with a copy to ADRS.

7. If the participant/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. ADRS will be responsible for defending any appeal of the administrative decision.

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 participants.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency does operate an Informal Conference as another dispute resolution process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a Fair Hearing.

At the Informal Conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the Informal Conference, the participant, applicant, or his/her legal representative can submit a written request for a Fair Hearing within 30 days of the date of the Informal Conference decision. The document referring to the participants appeal rights is maintained in the waiver participants home for future reference.

The Alabama Medicaid Agency will provide an opportunity for a Fair Hearing under 42 C.F.R. Part 431 Subpart E for participants who are dissatisfied after the above procedures are completed. A written request for a hearing must be filed within 30 days following the action with which he/she is dissatisfied. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within ten days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated participant or sponsor, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of Federal or State law or policy. However, the state does offer a hearing in these cases.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all participants.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The grievance/complaint system for the SAIL Waiver is managed and maintained by ADRS. ADRS has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

The Administering Agency, Alabama Medicaid, monitors and tracks resolution of grievances and complaints. Information is transmitted to the Medicaid Agency through a complaint and grievance log maintained by ADRS and submitted quarterly to the Medicaid Agency.

ADRS is responsible for explaining the procedures to clients of filing complaints and grievances. ADRS must also have procedures in place that will assure Alabama Medicaid that Direct Service Providers (DSP) explained to clients the process on how to register a complaint. Waiver applicants/participants are informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility. ADRS shall provide the participant written information about filing complaints and grievances. The DSP's supervisors will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider, they should forward their complaint to appropriate agency and/or Alabama Medicaid. ADRS shall inform all participants that filing a grievance/complaint is not a prerequisite or substitute for an appeal. Recipients also can file complaints about service provision, quality of care, and access to care.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Rehabilitation Services (ADRS) is responsible for explaining the procedures to participants for filing complaints and grievances. At the time of admission/application, readmission, redetermination, reinstatement or transfer of eligibility, the case manager informs participant of procedures necessary to file a formal complaint or grievance regarding the availability, delivery or quality of services. The case manager leaves written materials about this process to be maintained in the participant's home as well at the time of discussion. ADRS must have procedures in place that will assure Alabama Medicaid that DSPs have explained to participants the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a participant against any DSP workers. Any action taken will be documented in the participant's record. If the participant is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or Alabama Medicaid.

a. Complaints are submitted to ADRS and a copy is forwarded to Alabama Medicaid and are investigated through resolution. Complaints may be submitted by phone call or written notification. A tracking log will be used to document the incidents and resolutions of incident. ADRS will also maintain a log of complaints and grievances received.
b. If complaints are received by Alabama Medicaid, a copy will be forwarded to ADRS immediately. If they are received by ADRS a copy will be forwarded to the Alabama Medicaid LTC Program Management Unit within two working days.
c. ADRS must investigate all complaints upon receipt of notification and follow through to resolution. Appropriate parties must initiate action within 24 hours if it appears that a participant's health and safety are at risk. If necessary the complainant will be interviewed.
d. A summary and plan of correction will be sent from ADRS to Alabama Medicaid for all complaints reported within 30 days of the request for the summary or plan of correction from Alabama Medicaid. The providers must forward their plan of corrections to ADRS who will in turn forward to Alabama Medicaid. Alabama Medicaid will evaluate the plan of correction within seven days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to ADRS within two days. The revised plan of correction will be resubmitted to Alabama Medicaid within two working days. If the summary or plan of correction carried out is found not to be responsive, ADRS will have up to 45 days to revise the plan and carry out the appropriate action.
e. ADRS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risk exists.
f. Final determinations including any adverse findings will be reported to Alabama Medicaid.
g. ADRS will forward all grievance logs to Alabama Medicaid quarterly for review, tracking, and assurance that resolutions have been completed.

The participant and/or care giver are informed on how to file a grievance and complaint and how the process works to resolution. The State has a fair hearing process for any adverse actions which is different than the grievance and complaint system.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

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

State Critical Event or Incident Requirements

The State requires that incidences of alleged abuse, neglect or exploitation are reported for review and follow-up action to the Department of Human Resources (DHR) Adult Protective Services Division at the local level in the participant/applicant's county of residence.

If the case manager or direct service provider worker become aware of any of the following critical incidents or events, the occurrences must be reported within the following established time frames through the Gateway to Community Living Portal.

Type of Incident	Timeframe for Report	Report to
Physical Abuse	Immediate	DHR/Case Manager
Sexual Abuse	Immediate	DHR/Case Manager
Verbal Abuse	Immediate	DHR/Case Manager
Neglect	Immediate	DHR/Case Manager
Self-Neglect	Immediate	DHR/Case Manager
Mistreatment	Immediate	DHR/Case Manager
Exploitation	Immediate	DHR/Case Manager
Natural Death	24-hours	Case Manager
Unexpected Death	Immediate	Case Manager
Natural Disaster	Immediate	Case Manager
Fire	24-hours	Case Manager
Fall	24-hours	Case Manager
Seizure	24-hours	Case Manager
Missing/Eloped Individual	Immediate	Case Manager
Unauthorized Restrictive Intervention	Immediate	Case Manager
Other	24-hours	Case Manager

DEFINITIONS

Physical Abuse - The intentional infliction of physical pain or injury by a caregiver or other person of necessary services to maintain physical and mental health.

Sexual Abuse - Any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include, but are not limited to, unwanted sexual contact or activity using force or threats, rape, incest, sodomy, and indecent exposure.

Verbal Abuse - The infliction of disparaging and angry outbursts such as name calling, blaming, threatening, or making derogatory comments that demean or could reasonably be expected to cause shame, ridicule, humiliation, or emotional distress.

Neglect - The intentional or unintentional failure of a caregiver to provide food, shelter, clothing, medical services, supervision, or basic needs for safety for an individual who is unable to care for himself or herself.

Self-Neglect - The failure of the person to provide for their own basic needs when the failure is the result of the person’s mental or physical inability, and such failure substantially endangers a person’s health, safety, welfare, or life.

Mistreatment - Any act or threat of intimidation, harassment, or similar deed to cause harm or create the fear of harm to a vulnerable person by the caregiver or another person.

Exploitation - The expenditure, diminution or use of the property, assets, or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Natural Death - the permanent suspension of consciousness and the end of life due to natural causes.

Unexpected Death - The permanent suspension of consciousness and the end of life due to an unknown or unanticipated cause. At a minimum, unanticipated causes include those that resulted from suicide, homicide or other criminal activity, medical error or complications, undiagnosed conditions, or accidents, or those that were suspicious for possible abuse or neglect.

Natural Disaster - A situation in which a person is injured, killed, displaced, evacuated from his/her home due to damage or risk of damage resulting from a natural hazard such as tornados, hurricanes, floods, power outages, and winter weather.

Fire - A situation in which a person, object, building, or area of land is destroyed or damaged by burning.

Fall- Sudden and involuntary drop from an upright position to a lower surface or the ground.

Seizure - An unexpected or uncharacteristic seizure type, duration whether an injury occurs.

Missing/Eloped Individual - A person who cannot be located and there is reason to believe the person may be lost or in danger.

Unauthorized Restrictive Intervention - Impeding a waiver participant’s freedom of movement through any means, including blocking, manual holding, using seat belts or other restraining devices that are not medically prescribed, including holding or disabling a waiver participant’s wheelchair or other mobility device; the use of medication to control behavior or restrict the person’s freedom of movement; or forcing any seclusion that is not documented infection control purposes. An unauthorized restrictive intervention does not include any method that is routinely used during a medical procedure.

Other - Any other occurrence that requires the notification of agencies such as Police, Fire Department or any event resulting in DHR involvement/notification not already listed.

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human Resources, law enforcement authorities, physicians, caregiver, individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976 requires all physicians, osteopaths, chiropractors and caregivers by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the DSP are responsible for providing training and/or education to participants, and families or legal representatives about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with participants to encourage them to talk about what is important to them as well as what they do not like. Case Management training stresses the importance of establishing rapport with the participant, family and/or their legal representatives. Each participant is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the participant's rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand. The case manager and the DSP are responsible for informing the participant or responsible party of their right to lodge and how to register a complaint alleging abuse, neglect or exploitation. Information/training is provided and discussed with the participant and/or care giver as needed and annually.

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.

Alabama Department of Rehabilitation Services (ADRS) is the entity which receives reports of critical events or incidents. ADRS investigates the critical events reported via phone call and makes a recommendation within seven working days. If no recommendations can be made, additional information is gathered. Resolution of critical events and incidents is reached within seven working days from receipt of the additional information. The resolution of the event or incident is disseminated to all parties involved including the participants family or legal representative and other relevant parties. All allegations of abuse, neglect, or exploitation require a referral and investigation by the Alabama Department of Human Resources. If ADRS determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and make arrangements when appropriate.
Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 45 days based on the nature of the incident.

The case manager along with ADRS will review critical events/incidents to determine a pattern of problems in order to assure that no health and safety risk exists. Final determinations, including any adverse findings will be reported to Alabama Medicaid.

Reported critical events/incidents received by the Medicaid Agency will be submitted to ADRS within two working days. If critical events/incidents are submitted to ADRS, Medicaid must be notified within two working days after receipt. ADRS must investigate all reports of critical events/incidents upon receipt of notification.
Appropriate parties must act within 24 hours if it appears that a participant's health and safety is at risk. In these cases, the Medicaid Agency must be notified within one working day of the action taken. ADRS will interview the reporter if necessary.

All critical events/incidents will be analyzed to detect trends, patterns, and to assure the health and safety of the waiver participants. All adverse findings and final determinations will be reported to the SAIL program manager for review.

ADRS critical events/incidents log will be forwarded to Alabama Medicaid quarterly to assure that appropriate resolutions are carried out.

All Medicaid approved providers who provide home and community-based services in Medicaid participant's home shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976. Other critical incidents must be reported within 24 hours to the service provider, ADRS, and Alabama Medicaid in a timely manner based upon the circumstances surrounding the incident. ADRS will investigate the critical events reported and make a decision re: what actions are to be taken. ADRS is responsible for determining the need for follow-up. Completion of follow- up is not to exceed 60 days based on the nature of the incident. The case manager will notify the participant and/or caregiver of the results by phone, letter, or face-to-face visit depending on the event/incident.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

The Alabama Medicaid Agency is responsible for the oversight of ADRS reports and responses to critical incidents or events which impact waiver participants. When incidents are noted in the quarterly surveys, ADRS is notified in writing. The critical events/incidents is noted and tracked until the incident is resolved and ADRS reports resolution to Alabama Medicaid.

Alabama Medicaid conducts an annual review of ADRS includes a review of participant files and home visits. During the review Alabama Medicaid QA exercises the oversight of critical incidents and events by reviewing any documentation contained in participant files which reflects a report. QA staff look for documentation that the report has been addressed and resolved. If QA staff find documentation regarding a report of critical event/incident and no follow-up or resolution is documented, ADRS cited and must follow-up and resolve and/or submit a Corrective Action Plan. During reviews of the participant files, QA staff look for documentation in the file which indicates the participant is informed and knowledgeable about the complaint and grievance process.

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 Alabama Department of Rehabilitation Services (ADRS), Alabama Department of Human Resources, and Alabama Medicaid Agency is responsible for detecting the unauthorized use of restraints in Alabama by conducting monthly monitoring of participants health and welfare and provider quality reviews. Certain incidents of abuse, neglect and exploitation must be reported to ADHR by law. The Alabama Medicaid Agency conducts annual reviews of ADRS's investigations.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

ADRS, in its function of certifying providers, and in its monitoring of direct service provision and person-centered care 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 at monthly face to face visits.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The state agency responsible for detecting the use of seclusion is ADRS by monitoring participant health and welfare monthly with provider quality reviews. The Case Manager/ADRS will report any allegations of seclusion to Alabama Medicaid and Alabama Department of Human Resources if appropriate. The Direct Service Provider may also report an allegation of seclusion to ADRS.

The Department of Human Resources monitors reports of abuse, neglect and exploitation.

Alabama Medicaid conducts annual reviews of ADRS investigations.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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 participant records reviewed that do not identify previously unreported incidents of abuse, neglect, mistreatment, exploitation, and unexplained deaths. 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):
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% confidence level +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

		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 providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation]/ DENOMINATOR [Number of providers]

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of abuse, neglect, exploitation, or unexpected death incidents reviewed/investigated within the required timeframe. NUMERATOR [Total number of abuse, neglect and exploitation or unexpected death incidents reviewed/investigated within the required timeframe]/ DENOMINATOR [Number of abuse, neglect and exploitation or unexpected death incidents]

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of closed cases of abuse/neglect/exploitation for which the OA verified that the investigation conducted by the provider was done in accordance with state policy. NUMERATOR [Number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with state policy] / DENOMINATOR [Number of closed cases of abuse/neglect/exploitation]

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of suspected abuse, neglect & 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]/ DENOM [# of instances of suspected ANE and unexpected deaths]

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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 case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation]/ DENOMINATOR [Number of case managers]

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

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

	Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents that have been resolved by the OA within 60 days of the date of the critical incident report date. NUMERATOR [Number of critical incidents resolved by the OA within 60 days of the date of the critical incident report date]/ DENOMINATOR [Number of reported critical incidents]

Data Source (Select one):

Critical events and incident reports
If 'Other' is selected, specify:

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of critical incident trends where systemic intervention was implemented. NUMERATOR [Total number of critical incident trends where systemic intervention was implemented] / DENOMINATOR [Number of critical incident trends]

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident trends for which systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a corresponding revision to the intervention. NUM [Total number of critical incident trends where systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a

Data Source (Select one):
Other
If 'Other' is selected, specify:
cont'd from above: corresponding revision to the intervention]/ DENOM [Number of critical incident trends for which systemic intervention was implemented] Critical events and incident reporting

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

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

Data Aggregation and Analysis:

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

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.
NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] / DENOMINATOR [Number of participant records reviewed]

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

Responsible Party for data collection/generation *(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 interval with a margin of error of +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: 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:
 # and % of participant records reviewed that document training and education were provided to provider staff on how to identify and address health concerns of a participant, including any change in a participant's status that could jeopardize their health and safety in the community. NUM [# of participant record reviews documenting train. and ed. were provided to provider staff on how to identify

Data Source (Select one):
Other
If 'Other' is selected, specify:
and address health concerns of a participant] / DENOM [Number of participant records reviewed] SOURCE Training Verification Records

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

Data Aggregation and Analysis:

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

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 people who responded that their overall health was Good, Very Good, or Excellent. 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 Aggregation and Analysis:

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

Performance Measure:

Number and percent of participants reviewed who had an ambulatory or preventive care visit during the year. NUMERATOR [Number of participants who had an ambulatory or preventive care visit during the year] / DENOMINATOR [Number of participants]

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 case manager will monitor participants through monthly home visits to observe the participant and the home and note any critical events/incidents appropriately. The case manager will also report any events of this nature to the waiver administrator in the approved format who will forward to Alabama Medicaid within the required guidelines. The case manager will track reports to resolution for documentation and will report the resolution to the waiver administrator to forward to Alabama Medicaid.

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.

Alabama Medicaid has developed a Quality Management Strategy for the SAIL Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant homes, and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; (4) Collect data and submit quarterly and annual reports to ADRS and Alabama Medicaid staff for evaluation and recommendations for program improvements.

When complaints and grievances arise every attempt is made to resolve them at the local level. When this effort is not successful the grievance process is initiated. Waiver participants are encouraged to advise the case manager of any dissatisfaction relative to any aspect of the care or services received through the SAIL Waiver. Participants may register a complaint or grievance relating to denial, reduction or change in waiver services, financial eligibility, Direct Service Providers, Direct Service Workers or with the case manager. If the complaint or grievance is lodged against the case manager ADRS is responsible for resolving the concerns. If the complaint or grievance is lodged against ADRS, Alabama Medicaid is responsible for resolving the concerns.

If complaints are received by the Medicaid Agency, a copy will be forwarded to SAIL Waiver program administrator within two (2) working days. All complaints are investigated upon receipt of notification. Appropriate parties must initiate follow-up within 24 hours if it appears that a participant's health and safety is at risk. If necessary, the complainant will be interviewed. A summary and plan of correction will be developed by the Medicaid Reviewer for complaints reported. The DSP must forward their summaries and plans of correction to the Medicaid Agency, who will in turn forward them to the ADRS SAIL Waiver program administrator for review. The administrator will evaluate the plans of correction within seven (7) days of receipt. If the plan of correction submitted by the DSP Agency is found not to be responsive to the complaint, the administrator will return the plan to the DSP Agency requesting a resubmitted plan within two (2) working days of receipt of notice. If the summary or plan of correction carried out by the DSP Agency continues to be unresponsive, the DSP Agency will have up to forty-five
(45) days to revise the plan and carry out the appropriate action. Final determinations including any adverse findings will be reported to the SAIL Waiver program administrator. The Medicaid Agency will contact the participant via telephone to ensure full resolution to the incident has been completed satisfactory.

Complaints received by the Medicaid Agency will be submitted to ADRS within 2 working days. If complaints are submitted to ADRS, Medicaid must be notified within 2 working days after the complaint is received. ADRS must investigate all complaints upon receipt of notification. Appropriate parties must take action if it appears that a participant health and safety is at risk within 24 hours. In these cases, the Medicaid Agency must be notified within one (1) working day of the action taken. The complainant will be interviewed if necessary. A summary and plan of correction will be sent from ADRS or the provider for all complaints reported to the Medicaid Agency Quality Assurance Division. The Medicaid Agency will evaluate the plan of correction. If the plan of correction is not responsive to the complaint it will be returned to ADRS. The corrective plan of correction will be sent to the Medicaid Agency within 2 working days. The Medicaid Agency will contact the participant and/or responsible party and the case manager via telephone to ensure full complaint resolution has been reached.

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 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.

Alabama Medicaid is responsible for collecting data from ADRS quarterly and annually regarding the quality of services provided from various sources for the SAIL Waiver program. The Quality Framework is used as a guide to assess seven (7) Program Design Focus areas from samples of waiver participants, case management and direct service providers records, and on-site home visits when deemed necessary. In addition, complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participant's satisfaction with resolutions.

Data is collected through annual record reviews and the review of ADRS which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all applicants approved by Alabama Medicaid is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of case managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the participant are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting ADRS to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. Alabama Medicaid in collaboration with the LTC Division, will evaluate reports and make recommendations for improvements to the program. The Alabama Medicaid LTC Division will determine if changes are made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.
Participant Access:
Sources of data
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant Centered Service Planning and Delivery:
Sources of data
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities:
Sources of data
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards:
Sources of data
Case Management Records
Consumer Surveys
Home Visits
Site Visits

Participants Rights and Responsibilities:
Sources of data
Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction:
Sources of data
Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance:
Sources of data
Review of Operating Agency Quality Assurance System Review of Operating Agency Billing and Service Provision
Collaborative Meeting with ADRS to enhance the administration of the Program Subcontractor Participant Records

The following indicators are reported to the operating agency and Medicaid's Long Term Care Division:
Percentage of participant/family reporting satisfaction with waiver services and needs met.
Percentage of participant/family reporting they feel safe and secure in the home and community.
Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.
Percentage of participant/family reporting knowledge of rights and responsibilities.
Percentage of records indicating services are planned and implemented according to the participants needs and preferences.
Evidence that ADRS has a Quality Assurance System in place that monitors DSPs.
Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Alabama Medicaid QA conducts quarterly meetings with the Program Manager to discuss data/findings and develop strategies to improve or correct systems. Alabama Medicaid QA and the Program Manager then conduct a meeting with ADRS to discuss data/findings and implement or continue to develop strategies to improve or correct systems. Follow-up meetings and trainings are to implement changes and updates. Both ADRS and Alabama Medicaid are involved in system improvements.

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:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

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.

Alabama Medicaid is responsible for collecting data regarding the quality of services provided from various sources for the SAIL Waiver. Data is collected using quality indicators areas of the Quality Framework as a guide. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Collected data is reported quarterly and annually to ADRS and to Alabama Medicaid's LTC Division for evaluation and recommendations for program improvements. Alabama Medicaid is the administering authority over the SAIL Waiver Program; therefore, recommendations for improvements will be evaluated for final determination of changes to the program.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

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

Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Alabama Medicaid's Electronic Visit Verification and Monitoring System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

How does the EVVM system work?
1. When a service is authorized for a member, a schedule can be entered into the EVVM system.
2. The provider agency employee (worker) arrives at the member location to provide a service.
3. The worker checks into the system using the following:
- The worker's mobile device to log the visit using the EVVM app (or the recipient phone will be utilized to dial into the Interactive Voice Response (IVR) system as the authorized back-up method).
- The worker enters their worker ID, selects the recipient and the service they are going to perform.
4. Using GPS technology, the location from which the service is rendered is validated.
5. The system verifies that the worker is appropriate to provide the prior authorized service for the member and advises the worker that he/she is checked in.
6. After the worker performs the service, the worker checks out using the same process and indicates specific tasks performed.
7. Claims will be available for the provider's review via the EVVM system website in real-time.
8. After the provider's review, the provider should confirm the claim.
9. Once confirmed, claims are automatically submitted for payment.

ADRS will have their records audited at least annually at the discretion of the Alabama Medicaid Agency.

Payments to the OA for administrative services are adjusted to actual cost at the end of each waiver year. The OA submits documentation to Medicaid before the first day of the third month of the next quarter. The quarterly cost report includes all actual costs incurred by the OA for the previous quarter and includes costs incurred for the current year to date. Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed. Medicaid will recover payments that exceed actual allowable cost.

Alabama Medicaid's post-payment financial audit program for the SAIL Waiver is designed to ascertain that only reasonable and allowable expenses are included in the cost report received from the OA. Cost reports are due to Medicaid no later than 90 days after the fiscal year end. An audit of the cost reports is conducted annually. These audits are limited in scope. The auditor will conduct a sampling process of the OA's expenditures. The sample includes, but is not limited to: provider contracts, cost allocation, previous audits, cash disbursements, general ledger accounts, cash receipts, verification of deposits, payroll records including employee electronic time sheets and cancelled checks, vendor invoices and all vouchers or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditor's findings and opinion regarding compliance and internal control. After the sample is completed, the auditor will make adjustments to the cost report if necessary. ADRS's adjusted cost report is compared to Medicaid's paid file for final settlement.

In the accordance with the Single Audit Act. ADRS and Alabama Medicaid are audited externally by the Alabama Department of Public Examiners of Public Accounts. Annually, the state submits a SEFA (Statement of Expenditures of Federal Award) to the Examiners of Public Accounts. The Waiver programs are shown in CFDA 93.778M.

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. 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):*
Record reviews, on-site
If 'Other' is selected, specify:
Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *random sampling conducted at a confidence level of plus or minus five and a confidence level of 90%.*
☐ ***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. 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 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 provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. NUMERATOR [Number of rates that remain consistent with the approved rate methodology] / DENOMINATOR [Number of rates reviewed]

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

The AMA has contracted with a fiscal agent to maintain the payment records on services received and billed under the SAIL Waiver. ADRS ensures that all services and corresponding payments are coded and documented properly. ADRS ensures that only those services included on the plan of care are billed for the SAIL Waiver participant.
On October 1, 2017, the Alabama Medicaid Agency will implement an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's Electronic Visit Verification and Monitoring System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and SAIL Waiver eligibility before the claims are paid. AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.

AMA through the Decision Support System can generate ad hoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.

b. Methods for Remediation/Fixing Individual Problems

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

Alabama Medicaid has developed a Quality Management Strategy for the SAIL Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant homes, and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; (4) Collect data and submit quarterly and annual reports to ADRS and Alabama Medicaid staff for evaluation and recommendations for program improvements.

When complaints and grievances arise every attempt is made to resolve them at the local level. When this effort is not successful the grievance process is initiated. Waiver participants are encouraged to advise the case manager of any dissatisfaction relative to any aspect of the care or services received through the SAIL Waiver. Participants may register a complaint or grievance relating to denial, reduction or change in waiver services, financial eligibility, Direct Service Providers, Direct Service Workers or with the case manager. If the complaint or grievance is lodged against the case manager ADRS is responsible for resolving the concerns. If the complaint or grievance is lodged against ADRS, Alabama Medicaid is responsible for resolving the concerns.

If complaints are received by the Medicaid Agency, a copy will be forwarded to SAIL Waiver program administrator within two (2) working days. All complaints are investigated upon receipt of notification. Appropriate parties must initiate follow-up within 24 hours if it appears that a participant's health and safety is at risk. If necessary, the complainant will be interviewed. A summary and plan of correction will be developed by the Medicaid Reviewer for complaints reported. The DSP must forward their summaries and plans of correction to the Medicaid Agency, who will in turn forward them to the ADRS SAIL Waiver program administrator for review. The administrator will evaluate the plans of correction within seven (7) days of receipt. If the plan of correction submitted by the DSP Agency is found not to be responsive to the complaint, the administrator will return the plan to the DSP Agency requesting a resubmitted plan within two (2) working days of receipt of notice. If the summary or plan of correction carried out by the DSP Agency continues to be unresponsive, the DSP Agency will have up to forty-five

(45) days to revise the plan and carry out the appropriate action. Final determinations including any adverse findings will be reported to the SAIL Waiver program administrator. The Medicaid Agency will contact the participant via telephone to ensure full resolution to the incident has been completed satisfactory.

Complaints received by the Medicaid Agency will be submitted to ADRS within 2 working days. If complaints are submitted to ADRS, Medicaid must be notified within 2 working days after the complaint is received. ADRS must investigate all complaints upon receipt of notification. Appropriate parties must take action if it appears that a participant health and safety is at risk within 24 hours. In these cases, the Medicaid Agency must be notified within one (1) working day of the action taken. The complainant will be interviewed if necessary. A summary and plan of correction will be sent from ADRS or the provider for all complaints reported to the Medicaid Agency Quality Assurance Division. The Medicaid Agency will evaluate the plan of correction. If the plan of correction is not responsive to the complaint it will be returned to ADRS. The corrective plan of correction will be sent to the Medicaid Agency within 2 working days. The Medicaid Agency will contact the participant and/or responsible party and the case manager via telephone to ensure full complaint resolution has been reached.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group*

services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The AMA does not formally publish rates for SAIL waiver services. However, AMA will furnish the rates when requested. Rates for SAIL Waiver services are established by Medicaid. If rate adjustments are retroactive, then previously paid claims will be recouped and repaid at the adjusted rate.They are prospective rates that are based on audited historical costs with consideration given to the health care index and renegotiated contracts. Medicaid pays private and public contractors the same rate. The OA may request an interim increase or decrease at any time. At fiscal year end, the total amount paid by the OA is divided by the total number of units served, and an average rate per service is determined. Medicaid uses the average rate to determine the final settlement.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the States determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

As each waiver year is audited, this cost like the benefit cost, will be determined and lump sum settlement will be made to adjust that years payments to actual cost. The Cost Report from the OA is due to Medicaid by December 31. Cost settlements are made no later than September 30 of the following year.
As of 2011, the SAIL waiver transition to a cost-based waiver. This waiver is cost-settled and audited by Medicaid's Provider Audit Division. Cost settlements include services and administrative cost.
The procedure codes for these rates are on the pricing file and may be adjusted based upon the following:
- *If the Operating Agency costs are more than estimated for the services provided, the Medicaid Agency may owe the OA monies that will assist them in recovering their cost. This is the cost settlement. The OA can also request an increase in the rate for subsequent years so that the rate on the file is closer to their actual cost. If this occurs, when the cost settlement is done, Medicaid should owe the OA less in the cost settlement.*
- *If the Operating Agency costs are less than estimated for the services, the OA may owe the Medicaid Agency monies. In this instance, the OA can also request a decrease in the rate for subsequent years so that the rate on the file is closer to the actual cost. If this occurs, the OA should owe Medicaid less in the cost settlement.*

The estimated rate is the rate listed on the Operating Agency Pricing File.

Waiver participants, providers, or anyone who is interested in viewing the rates may access the waiver document on the Alabama Medicaid website.

Rates for all services are reviewed annually. If necessary they may be reexamined at any time. Stakeholders, participants, and providers may submit information or request information regarding the rate methodology at any time.
Alabama also performs periodic evaluations and assessments to determine if the rates are consistent with efficiency, economy, and quality of care. We also periodically survey providers to request their feedback on rates.

The last review of the waiver rate methodology was November 13, 2019.

Public comments and responses can be reviewed in the Main Module 6-I of this application.

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 Medicaids Long Term Care File. This file holds approved dates of eligibility for waiver services.

Provider billings flow directly from the providers to Medicaid MMIS and the Fiscal Intermediary as follows:

Payments made by Medicaid to providers are on a cost reimbursement basis. Each covered service is identified on a claim by a HCPC 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. Each service type is identified by Procedure Code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.

If the submitted claims cover dates of service where part, or all of the claim was previously paid, the 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 12 months from the date of service. Medicaid recovers payments that exceed actual allowable cost.

Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement.

Participant-directed billings flow directly from the FMSA to the OA. The OA bills Medicaid a monthly claim for each participant. The OA monitors the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours. Remediation of the problem will be expected within 48 hours of the FMSA being notified by the operating agency.

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 recipients name matches the recipient identification number (RID); the HCPC code is valid for the diagnosis; the recipient is eligible; the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim 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 the fiscal agent personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published by the Alabama Medicaid Agency. The check is sent to the providers payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the providers bank account and the EOP is mailed separately to the provider.
The case managers check the service plan against the direct service provider service logs to determine if services were rendered according to the service plan. Monthly notes and discrepancies are documented in the case file. Recoupments and violations are processed and communicated with the direct service provider.

The Operating Agency has a designated person who validates indirect services for Medicaid reimbursement. Time logs and other documents are check for billing approval.

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:

The State of Alabama Department of Rehabilitation Services is the operating agency for the SAIL Waiver. This state agency provides case management services for the SAIL Waiver.

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 voluntarily reassign their right to direct payments to the State of Alabama Department of Rehabilitation Services (ADRS).

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:

ADRS and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish. Free choice of providers is assured by the policies and procedures in effect and practices carried out by the case managers. All providers are certified and monitored by Quality Assurance reviews performed by ADRS or Medicaid. Although the State does not have any OHCDS enrolled for the waiver we have a process to ensure that they may enroll with Medicaid. OHCDS will be certified by ADRS and AMA and monitored by the Quality Assurance Department by ADRS and AMA.

The OHCDS will enroll using our fiscal agent. AMA's systems has several edits and audits to ensure financial accountability.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The source of non-federal funds for the SAIL Waiver are general fund appropriations to ADRS. These funds are 106, general fund; 349, other funds such as federal, intergovernmental transfers, drug rebates, and other small amounts; 564, Health Care Trust Funds for provider taxes; and 1047, tobacco revenue. These funds are for the sole use of Medicaid once the appropriation is made by the Legislature. The Alabama Legislature does not line item budget any revenue or expenditure for Medicaid. In other words, no revenue comes to Medicaid earmarked for certain expenditures. It is up to Medicaid how a voucher is coded and thus charged. If Medicaid has any balance in fund 106 at the end of the year, it does not revert back to the State general fund.

The non-federal share is transferred to AMA by ADRS. AMA uses the IGT process which determines during the billing cycle how much the non-federal match is needed to reimburse adjusted claims and invoices. The source of the non-federal share is 100% appropriated by the State's legislature to ADRS.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*15873.87*	*9861.49*	*25735.36*	*58710.81*	*4009.33*	*62720.14*	*36984.78*
2	*16669.13*	*10157.33*	*26826.46*	*60472.14*	*4129.61*	*64601.75*	*37775.29*

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	17500.12	10462.05	27962.17	62286.30	4253.49	66539.79	38577.62
4	18404.40	10775.91	29180.31	64154.89	4381.10	68535.99	39355.68
5	19358.63	11099.19	30457.82	66079.54	4512.53	70592.07	40134.25

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	800	800
Year 2	800	800
Year 3	800	800
Year 4	800	800
Year 5	800	800

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of Stay is 336.1 days per year based upon the most recent CMS 372 report (Lag 2022-2023). Previous years show 331.3 (2021-2022) and 327.4 (2020-2021).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is derived from data in the CMS-372 Report for year 2023 (10/1/2022-9/30/2023) and claims data from the most recent waiver year.
D has increased slightly due to additional slots and services.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is derived from data in the CMS-372 Report for year 2023 (10/1/2022-9/30/2023) and claims data from the most recent waiver year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is derived from data in the CMS-372 Report for year 2022 (10/1/2022-9/30/2023) and claims data from the most recent waiver year.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is derived from data in the CMS-372 Report for year 2023 (10/1/2022-9/30/2023) and claims data from the most recent waiver year. Estimates of Factor G' will not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.

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	
Case Management	
Personal Care	
Unskilled Respite	
Medical Supplies	
Assistive Technology Repairs	
Assistive Technology	
Environmental Accessibility Adaptations (EAA)	
Evaluation for Assistive Technology	
Minor Assistive Technology	
Personal Assistance Service (PAS)	
Personal Emergency Response System (Installation)	
Personal Emergency Response System (Monthly Fee)	
Pest Control Service	
Supervisory Visit	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**2593399.14**
Case Management	☐	15 min	655	219.60	18.03	**2593399.14**	
Personal Care Total:							**8667949.53**
Personal Care	☐	15 min.	505	3874.55	4.43	**8667949.53**	
Unskilled Respite Total:							**5205.25**
Unskilled Respite	☐	15 min.	5	235.00	4.43	**5205.25**	
Medical Supplies Total:							**814528.04**
Medical Supplies	☐	1 Month	620	9.39	139.91	**814528.04**	
Assistive Technology Repairs Total:							**6147.30**
Assistive Technology Repairs	☐	1 per item basis	30	1.00	204.91	**6147.30**	
Assistive Technology Total:							**181902.15**
Assistive Technology	☐	1 per item basis	45	1.00	4042.27	**181902.15**	
Environmental Accessibility Adaptations (EAA) Total:							**125525.40**
Environmental Accessibility Adaptations (EAA)	☐	1 per item basis	33	1.00	3803.80	**125525.40**	
Evaluation for Assistive Technology Total:							**132.87**
Evaluation for Assistive Technology	☐	1 per item basis	3	1.00	44.29	**132.87**	
Minor Assistive Technology Total:							**44162.00**
Minor Assistive Technology	☐	1 per item basis	284	1.00	155.50	**44162.00**	
Personal Assistance Service (PAS)							**1772.00**

GRAND TOTAL:	**12699098.78**
Total: Services included in capitation:	
Total: Services not included in capitation:	12699098.78
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**15873.87**
Services included in capitation:	
Services not included in capitation:	15873.87
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance Service (PAS)	☐	15 min.	5	80.00	4.43	**1772.00**	
Personal Emergency Response System (Installation) Total:							**299.00**
Personal Emergency Response System (Installation)	☐	1 per item basis	1	1.00	299.00	**299.00**	
Personal Emergency Response System (Monthly Fee) Total:							**65636.10**
Personal Emergency Response System (Monthly Fee)	☐	1 month	233	10.00	28.17	**65636.10**	
Pest Control Service Total:							**30000.00**
Pest Control Service	☐	1 per series/unit	10	1.00	3000.00	**30000.00**	
Supervisory Visit Total:							**162440.00**
Supervisory Visit	☐	1 every 60 days	655	8.00	31.00	**162440.00**	

GRAND TOTAL:	**12699098.78**
Total: Services included in capitation:	
Total: Services not included in capitation:	12699098.78
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**15873.87**
Services included in capitation:	
Services not included in capitation:	15873.87
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**2724241.41**
Case Management	☐	15 min	668	226.19	18.03	**2724241.41**	
Personal Care Total:							**9104787.85**
Personal Care	☐	15 min.	515	3990.79	4.43	**9104787.85**	
Unskilled Respite Total:							**5361.41**
Unskilled Respite	☐	15 min.	5	242.05	4.43	**5361.41**	
Medical Supplies Total:							**855456.54**
Medical Supplies	☐	1 month	629	9.53	142.71	**855456.54**	
Assistive Technology Repairs Total:							**1414.22**
Assistive Technology Repairs	☐	1 per item basis	31	1.00	45.62	**1414.22**	
Assistive Technology Total:							**191522.84**
Assistive Technology	☐	1 per item basis	46	1.00	4163.54	**191522.84**	
Environmental Accessibility Adaptations (EAA) Total:							**133208.94**
Environmental Accessibility Adaptations (EAA)	☐	1 per item basis	34	1.00	3917.91	**133208.94**	
Evaluation for Assistive Technology Total:							**136.86**
Evaluation for Assistive Technology	☐	1 per item basis	3	1.00	45.62	**136.86**	
Minor Assistive Technology Total:							**46449.30**
Minor Assistive Technology	☐	1 per item basis	290	1.00	160.17	**46449.30**	
Personal Assistance Service (PAS)							**1825.16**

GRAND TOTAL:	**13335302.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	13335302.35
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**16669.13**
Services included in capitation:	
Services not included in capitation:	16669.13
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance Service (PAS)	☐	15 min.	5	82.40	4.43	**1825.16**	
Personal Emergency Response System (Installation) Total:							**307.97**
Personal Emergency Response System (Installation)	☐	1 month	1	1.00	307.97	**307.97**	
Personal Emergency Response System (Monthly Fee) Total:							**69055.94**
Personal Emergency Response System (Monthly Fee)	☐	1 month	238	10.30	28.17	**69055.94**	
Pest Control Service Total:							**30900.00**
Pest Control Service	☐	1 per series/unit	10	1.00	3090.00	**30900.00**	
Supervisory Visit Total:							**170633.92**
Supervisory Visit	☐	15 min	668	8.24	31.00	**170633.92**	

GRAND TOTAL:	**13335302.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	13335302.35
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**16669.13**
Services included in capitation:	
Services not included in capitation:	16669.13
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**2860505.84**
Case Management	☐	15 min	681	232.97	18.03	**2860505.84**	
Personal Care Total:							**9560018.63**
Personal Care	☐	15 min.	525	4110.51	4.43	**9560018.63**	
Unskilled Respite Total:							**5522.22**
Unskilled Respite	☐	15 min.	5	249.31	4.43	**5522.22**	
Medical Supplies Total:							**899434.16**
Medical Supplies	☐	1 month	639	9.67	145.56	**899434.16**	
Assistive Technology Repairs Total:							**1456.69**
Assistive Technology Repairs	☐	1 per item basis	31	1.00	46.99	**1456.69**	
Assistive Technology Total:							**201556.68**
Assistive Technology	☐	1 per item basis	47	1.00	4288.44	**201556.68**	
Environmental Accessibility Adaptations (EAA) Total:							**137205.30**
Environmental Accessibility Adaptations (EAA)	☐	1 per item basis	34	1.00	4035.45	**137205.30**	
Evaluation for Assistive Technology Total:							**140.97**
Evaluation for Assistive Technology	☐	1 per item basis	3	1.00	46.99	**140.97**	
Minor Assistive Technology Total:							**48666.15**
Minor Assistive Technology	☐	1 per item basis	295	1.00	164.97	**48666.15**	
Personal Assistance Service (PAS)							**1879.87**

GRAND TOTAL:	**14000092.96**
Total: Services included in capitation:	
Total: Services not included in capitation:	14000092.96
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**17500.12**
Services included in capitation:	
Services not included in capitation:	17500.12
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance Service (PAS)	☐	15 min.	5	84.87	4.43	**1879.87**	
Personal Emergency Response System (Installation) Total:							**317.21**
Personal Emergency Response System (Installation)	☐	1 month	1	1.00	317.21	**317.21**	
Personal Emergency Response System (Monthly Fee) Total:							**72329.86**
Personal Emergency Response System (Monthly Fee)	☐	1 month	242	10.61	28.17	**72329.86**	
Pest Control Service Total:							**31827.00**
Pest Control Service	☐	1 per series/unit	10	1.00	3182.70	**31827.00**	
Supervisory Visit Total:							**179232.39**
Supervisory Visit	☐	15 min	681	8.49	31.00	**179232.39**	

GRAND TOTAL:	**14000092.96**
Total: Services included in capitation:	
Total: Services not included in capitation:	14000092.96
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**17500.12**
Services included in capitation:	
Services not included in capitation:	17500.12
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**3006902.77**
Case Management	☐	15 min	695	239.96	18.03	**3006902.77**	
Personal Care Total:							**10053144.66**
Personal Care	☐	15 min.	536	4233.83	4.43	**10053144.66**	
Unskilled Respite Total:							**5687.90**
Unskilled Respite	☐	15 min.	5	256.79	4.43	**5687.90**	
Medical Supplies Total:							**944768.06**
Medical Supplies	☐	1 month	648	9.82	148.47	**944768.06**	
Assistive Technology Repairs Total:							**1548.80**
Assistive Technology Repairs	☐	1 per item basis	32	1.00	48.40	**1548.80**	
Assistive Technology Total:							**212020.80**
Assistive Technology	☐	1 per item basis	48	1.00	4417.10	**212020.80**	
Environmental Accessibility Adaptations (EAA) Total:							**145477.85**
Environmental Accessibility Adaptations (EAA)	☐	1 per item basis	35	1.00	4156.51	**145477.85**	
Evaluation for Assistive Technology Total:							**145.20**
Evaluation for Assistive Technology	☐	1 per item basis	3	1.00	48.40	**145.20**	
Minor Assistive Technology Total:							**51145.92**
Minor Assistive Technology	☐	1 per item basis	301	1.00	169.92	**51145.92**	
Personal Assistance Service (PAS)							**1936.35**

GRAND TOTAL:	**14723519.15**
Total: Services included in capitation:	
Total: Services not included in capitation:	14723519.15
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**18404.40**
Services included in capitation:	
Services not included in capitation:	18404.40
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance Service (PAS)	☐	15 min.	5	87.42	4.43	**1936.35**	
Personal Emergency Response System (Installation) Total:							**326.73**
Personal Emergency Response System (Installation)	☐	1 month	1	1.00	326.73	**326.73**	
Personal Emergency Response System (Monthly Fee) Total:							**76050.83**
Personal Emergency Response System (Monthly Fee)	☐	1 month	247	10.93	28.17	**76050.83**	
Pest Control Service Total:							**36059.98**
Pest Control Service	☐	1 per series/unit	11	1.00	3278.18	**36059.98**	
Supervisory Visit Total:							**188303.30**
Supervisory Visit	☐	1 every 60 days	695	8.74	31.00	**188303.30**	

GRAND TOTAL:	**14723519.15**
Total: Services included in capitation:	
Total: Services not included in capitation:	14723519.15
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**18404.40**
Services included in capitation:	
Services not included in capitation:	18404.40
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**3159513.01**
Case Management	☐	15 min	709	247.16	18.03	**3159513.01**	
Personal Care Total:							**10567231.10**
Personal Care	☐	15 min.	547	4360.84	4.43	**10567231.10**	
Unskilled Respite Total:							**5858.45**
Unskilled Respite	☐	15 min.	5	264.49	4.43	**5858.45**	
Medical Supplies Total:							**993485.77**
Medical Supplies	☐	1 month	658	9.97	151.44	**993485.77**	
Assistive Technology Repairs Total:							**1595.20**
Assistive Technology Repairs	☐	1 per item basis	32	1.00	49.85	**1595.20**	
Assistive Technology Total:							**222930.89**
Assistive Technology	☐	1 per item basis	49	1.00	4549.61	**222930.89**	
Environmental Accessibility Adaptations (EAA) Total:							**154123.56**
Environmental Accessibility Adaptations (EAA)	☐	1 per item basis	36	1.00	4281.21	**154123.56**	
Evaluation for Assistive Technology Total:							**149.55**
Evaluation for Assistive Technology	☐	1 per item basis	3	1.00	49.85	**149.55**	
Minor Assistive Technology Total:							**53731.14**
Minor Assistive Technology	☐	1 per item basis	307	1.00	175.02	**53731.14**	
Personal Assistance Service (PAS)							**1994.39**

GRAND TOTAL:	**15486907.06**
Total: Services included in capitation:	
Total: Services not included in capitation:	15486907.06
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**19358.63**
Services included in capitation:	
Services not included in capitation:	19358.63
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance Service (PAS)	☐	15 min.	5	90.04	4.43	**1994.39**	
Personal Emergency Response System (Installation) Total:							**336.53**
Personal Emergency Response System (Installation)	☐	1 month	1	1.00	336.53	**336.53**	
Personal Emergency Response System (Monthly Fee) Total:							**79932.94**
Personal Emergency Response System (Monthly Fee)	☐	1 month	252	11.26	28.17	**79932.94**	
Pest Control Service Total:							**38256.02**
Pest Control Service	☐	1 per series/unit	11	1.00	3477.82	**38256.02**	
Supervisory Visit Total:							**207768.51**
Supervisory Visit	☐	15 min	723	9.27	31.00	**207768.51**	

GRAND TOTAL:	**15486907.06**
Total: Services included in capitation:	
Total: Services not included in capitation:	15486907.06
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**19358.63**
Services included in capitation:	
Services not included in capitation:	19358.63
Average Length of Stay on the Waiver:	336