

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

The State of Alabama requests to renew the Alabama Technology Assisted Waiver for Adults (TA Waiver).

Changes in this renewal include:

Throughout the Document

- Replace all occurrences of “AMA” with “Alabama Medicaid”.
- Replace the terms “recipient,” “client,” “individual,” or “applicant” with “participant”.
- Replace all references to “Plan of Care (POC)” with “Person-Centered Care Plan (PCCP)”.
- Clarify that all timeframes are expressed in business days unless otherwise required by federal regulation.
- Remove references to Individual Goods and Services, as these supports are available to participants solely through the State’s 1915(j) Personal Choices program.
- Revisions to ensure compliance with Instructions, Technical Guide and Review Criteria, Version 3.7 HCBS Waiver Application.
- Revisions to performance measures to align with other state waivers

Appendix A

- Appendix A-3: Updated and expanded descriptions of Alabama Medicaid oversight and the roles of contracted entities, including ADSS and the Financial Management Services Agency (FMSA), to meet Technical Guide v3.7 requirements.
- Clarified distinctions between administrative authority retained by Alabama Medicaid and operational functions delegated through written agreements.
- Updated Quality Improvement tables to reflect current processes and responsible entities.

Appendix B

- Appendix B-4-b: Updated Medicaid eligibility group selections to correctly reflect the adult-only target population and remove inapplicable eligibility categories.
- Appendix B-6-i: Added detailed procedures regarding timely annual level of care reevaluations, including the use of an electronic tracking (“tickler”) system and specific notification and submission timelines expressed in business days.
- Updated performance measures to reflect the current responsible agency, revised frequencies, and updated sampling approaches.
- Updated terminology references throughout to align with “participant,” “PCCP,” and other global language changes.

Appendix C

- Appendix C-2-d: Replaced prior placeholder text with full, Technical Guide v3.7-compliant language regarding Legally Liable Relatives (LLRs) furnishing personal care or similar services, including best-interest determinations, safeguards, and conflict-of-interest protections.
- Appendix C-2-e: Updated policies governing payment to relatives/guardians to align with self-direction requirements, clarify allowable relatives, and remove outdated references (e.g., “friends”).
- Updated all service definitions (e.g., Personal Care/Attendant Services, Private Duty Nursing, Specialized Medical Equipment, Medical Supplies, Pest Control) to:
 - Reflect PCCP terminology;
 - Distinguish provider qualifications for agency-based and self-directed workers;
 - Remove items considered State Plan DME;
 - Ensure alignment with Alabama’s Personal Choices 1915(j) authority.
- Updated provider qualification sections to remove outdated requirements (e.g., TB skin test for self-directed workers, if applicable).
- Revised service monitoring, supervision, and conflict-of-interest provisions to match Technical Guide v3.7 expectations.
- Updated Quality Improvement performance measures to reflect current responsible parties, frequencies, data sources, and sampling approaches.

The State is removing Individual Directed Goods and Services as a separately identified waiver service and incorporating allowable purchases into the existing participant-directed budgeting methodology under Personal Choices. Participants may continue to access approved goods and services through the individualized budget process and savings plan consistent with assessed need and the Person-Centered Care Plan (PCCP). This change aligns the waiver with current operational practices and simplifies service administration.

Appendix D

- Appendix D-1-a: Updated PCCP development language to clarify the respective roles of the ADSS case manager and Alabama Medicaid nurse reviewers (e.g., case manager leads PCCP development; nurse reviewer conducts clinical PDN review but does not author the PCCP).

Appendix E

- Updated cross-references and terminology to align with Personal Choices implementation and revised LLR and relative-payment standards.
- Updated FMSA references to reflect the correct contracted entity name and function.

Appendix F

- Updated participant rights and notice language to reflect PCCP terminology and business-day timeframes.
- Clarified fair hearing rights regarding choice of provider and denial, suspension, reduction, or termination of services.

Appendix H

- Updated Quality Improvement Strategy to reflect current processes for discovery, remediation, and system-level improvements.
- Revised performance measures to include updated responsible entities and explicitly describe documentation and corrective action requirements.

Appendix I

- Reviewed and updated financial accountability language to ensure clarity that administrative functions (e.g., provider supervision activities) are included within provider rates and not billed separately as waiver services.

Appendix J

- Updated reference-year data, projections, and service utilization estimates to reflect the removal of Individual Goods and Services and updated service definitions.
- Updated formulas and narrative explanations to maintain cost neutrality under revised service structures.
- Revised Private Duty Nursing service components and utilization assumptions to distinguish Registered Nurse (RN) and Licensed Practical Nurse (LPN) services consistent with billing practices and cost neutrality reporting methodologies.
- Revised Personal Care/Attendant Services utilization assumptions and service delivery distinctions to separately reflect traditional provider-managed and participant-directed Personal Choices services consistent with operational practices, reimbursement methodologies, and cost neutrality reporting.

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*):

Technology Assisted Waiver-TA 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.0407

Draft ID: AL.020.05.00

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

Regular Waiver

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

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the

Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

☒ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- ☐ Not applicable
- ☒ **Applicable**

Check the applicable authority or authorities:

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

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

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

Alabama TA Case Management Waiver (to be submitted)

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

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

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

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

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

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

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Technology Assisted (TA) Waiver for Adults is to provide home and community-based services to individuals who are 21 years of age or older with complex skilled medical conditions. These individuals have a medical history of being ventilator-dependent or have a tracheostomy. The TA Waiver is a community-based alternative for these adults who would otherwise require the nursing facility level of care if the TA Waiver services were not available.

The Alabama Medicaid Agency is responsible for operating the TA Waiver. The services include: Private Duty Nursing, Personal Care/Attendant Services, Medical Supplies, Assistive Technology, and Pest Control Service. Self-direction is offered for Personal Care/Attendant Services through the Personal Choices.

The TA Waiver participants can access Targeted Case Management activities through the Alabama Department of Senior Services.

This waiver participates in Alabama's Personal Choices Program. This is a State plan program available under 1915(j) to allow self direction for Personal Care/Attendant Services. To be eligible to receive services through the Personal Choices Program, the recipient must be a client receiving personal care. The Personal Choices Program option is placed on the POC for those clients who elect to receive personal care services through this option.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ☒ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - ☐ **No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the quality improvement strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to

individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ☒ **Not Applicable**
- ☐ **No**
- ☐ **Yes**

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

- ☒ **No**
- ☐ **Yes**

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

- ☐ **Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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 inpatients 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:

Periodic telephone interviews to waiver participants are performed by the Alabama Medicaid TA Coordinator or a designee, allowing them the opportunity to provide input. Input is also solicited during the monthly case management visit. Each participant receives a Problem Solving Guide at the time of the initial assessment and redetermination that provides the toll free telephone number to call to provide input. The public can make comment through the public Alabama Medicaid website by sending an e-mail to the Alabama Medicaid TA Coordinator at any time. Alabama Medicaid has ongoing opportunities to inform the public through presentations with various entities throughout the State each year. Alabama Medicaid also has information on its website to inform the public of all waiver programs available within the state including the contact information for each of the approved waivers.

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:

Wettingfeld

First Name:

Ginger

Title:

Director, LTC Healthcare Reform

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Ave.

Address 2:

P.O. Box 5624

City:

Montgomery

State:

Alabama

Zip:

36103-5624

Phone:

(334) 242-5018

Ext:

☐

TTY

Fax:

(334) 353-3642

E-mail:

ginger.wettingfeld@medicaid.alabama.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Alabama

Zip:

Phone:

Ext:

☐

TTY

Fax:

E-mail:

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
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Fax:

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E-mail:

Attachments

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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:

Individual Directed Goods and Services will no longer be included as a separately identified waiver service under this renewal. Participants utilizing the Personal Choices participant-directed option may continue to access allowable goods and services through their approved individualized budget and savings plan process, consistent with assessed need and the Person-Centered Care Plan (PCCP). Because these supports are currently available through the participant-directed budgeting methodology, no participant is expected to experience a reduction in access to approved goods and services as a result of this change.

Services and supports that were previously available through Assistive Technology will continue to be available through the Specialized Medical Equipment service, consistent with updated service definitions and waiver requirements.

The State will notify affected participants and/or their representatives of these changes in advance of implementation. Case managers will review each impacted participant's Person-Centered Care Plan (PCCP) and ensure services are appropriately reassigned to the correct service category without interruption.

If any adjustments to services are required as a result of these changes, the participant will be supported through the person-centered planning process to ensure continued access to necessary services and supports. The State will ensure that all participants continue to receive services sufficient to maintain their health and welfare.

Participants will be informed of their rights, including the right to request a Fair Hearing, in accordance with 42 CFR § 431 Subpart E.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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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:

Long Term Care Health Care Reform

(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:

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 indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

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.:*

Alabama Medicaid retains full administrative authority for the operation and oversight of the Technology Assisted (TA) Waiver in accordance with 42 CFR §431.10. Alabama Medicaid establishes policy, ensures compliance with federal requirements, executes provider agreements, oversees quality improvement activities, and monitors all contracted entities that perform waiver functions.

The Alabama Department of Senior Services (ADSS) performs case management functions under contract with Alabama Medicaid. ADSS case managers complete initial and annual assessments; facilitate development of the Person-Centered Care Plan (PCCP); monitor service delivery; and notify Alabama Medicaid of any changes in a participant's condition or needs.

The waiver operates concurrently with Alabama's 1915(j) Personal Choices self-directed option. ADSS contracts with a Financial Management Services Agency (FMSA) to:

- enroll self-directed workers;
- maintain provider agreements;
- process timesheets and payments;
- provide financial counseling and budget support; and
- ensure compliance with all requirements for self-directed service delivery.

Providers furnishing waiver services must meet the qualifications and standards described in Appendix C and must maintain a valid Medicaid provider agreement with Alabama Medicaid.

Alabama Medicaid conducts ongoing monitoring of contracted entities through quality reviews, performance reporting, and oversight mechanisms to ensure all delegated waiver functions are performed in accordance with Section 1915(c) requirements and Technical Guide v3.7 expectations.

- **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 retains full responsibility for the administration and oversight of all waiver services and supports furnished under the TA Waiver. Alabama Medicaid ensures that participants receive services in accordance with their assessed needs and the requirements of 42 CFR §441.301–§441.310.

Assessment and PCCP Development:

Initial and annual assessments are conducted by Alabama Department of Senior Services (ADSS) case managers under contract with Alabama Medicaid. ADSS case managers facilitate development of the Person-Centered Care Plan (PCCP) in collaboration with the participant and, as applicable, the participant's representative. The PCCP reflects the participant's goals, preferences, risks, strengths, and needs and includes all waiver and non-waiver services necessary to support the participant in the community. The PCCP must be completed and approved by Alabama Medicaid before the initiation or continuation of waiver services.

Service Authorization:

Alabama Medicaid reviews and authorizes all waiver services identified in the PCCP. For Private Duty Nursing (PDN), Alabama Medicaid nurse reviewers conduct a clinical review of medical necessity and ensure that PDN hours are appropriate and consistent with the participant's health and safety needs. Alabama Medicaid retains final authority for approval, modification, or denial of any service.

Monitoring and Coordination:

ADSS case managers monitor implementation of the PCCP through monthly contacts and a minimum of one face-to-face visit per month. Case managers must report to Alabama Medicaid any changes in the participant's condition or circumstances that may require revision of the PCCP or service authorization. Case managers ensure that services are delivered as authorized and address any gaps or concerns identified through monitoring.

Self-Direction through Personal Choices (1915(j)):

For participants who elect to self-direct Personal Care/Attendant Services through the Personal Choices program, ADSS contracts with a Financial Management Services Agency (FMSA) to support required employer- and budget-related functions. The FMSA enrolls self-directed workers, processes payments, provides financial counseling, and ensures adherence to all federal and state requirements for self-direction. Self-directed services must be included in the PCCP and authorized by Alabama Medicaid in the same manner as agency-based services. ADSS Personal Choices Counselors coordinate with the FMSA to ensure that the participant's PCCP and self-directed budget align and support identified needs.

Oversight:

Alabama Medicaid monitors the performance of ADSS, and all other contracted entities through periodic quality reviews, data monitoring, and ongoing oversight activities. Alabama Medicaid ensures that all delegated functions are carried out in compliance with federal waiver requirements and that participants receive services in accordance with their authorized PCCP.

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:

Alabama Medicaid uses multiple methods on an ongoing basis to assess the performance of contracted entities that carry out waiver operational and administrative functions for the TA Waiver. This includes the Alabama Department of Senior Services (ADSS), which performs case management under Targeted Case Management with Alabama Medicaid, and the Financial Management Services Agency (FMSA), which operates under contract with ADSS to support the Personal Choices self-directed option.

Assessment of ADSS (Case Management)

Alabama Medicaid conducts at least annual onsite reviews of ADSS in its role as case management provider for the TA Waiver. These reviews include examination of participant records, PCCPs, monitoring documentation, staff qualifications and training, and evidence that case management activities are performed in accordance with waiver requirements.

Alabama Medicaid evaluates whether:

- Level of care criteria and admission requirements are met;
- PCCPs are person-centered, complete, and aligned with assessed needs;
- Participant rights and freedom of choice are consistently explained and documented;
- Monthly monitoring and required face-to-face visits occur as required; and
- Authorized services are delivered as planned.

Alabama Medicaid also reviews ADSS complaint and grievance procedures, documentation practices, and resolution processes to ensure that participant health and welfare are protected and that appeals are afforded in accordance with federal requirements.

Assessment of Participant Experience

Alabama Medicaid reviews TA Waiver participant satisfaction survey results and participant feedback received throughout the year. Survey data, participant inquiries, and reported concerns inform technical assistance needs and identify areas for improved performance. Follow-up is conducted as needed to ensure operational and administrative functions are performed appropriately.

Assessment of the FMSA (Contracted Through ADSS)

ADSS contracts with a Financial Management Services Agency (FMSA) to perform required employer- and budget-related functions under the Personal Choices self-directed option. Although ADSS holds the contractual relationship, Alabama Medicaid retains oversight responsibility for ensuring the FMSA meets all federal and state requirements.

Alabama Medicaid assesses FMSA performance through:

- Review of FMSA reports submitted to ADSS and Alabama Medicaid;
- Reconciliation of payment and budget data;
- Evaluation of provider enrollment and payment processing practices;
- Review of financial counseling and participant support activities; and
- Monitoring compliance with all timelines and reporting requirements established in the ADSS–FMSA contract.

Frequency of Assessments

Annual:

- Onsite administrative and case record reviews of ADSS.
- Structured review of ADSS policies, procedures, and staff records.

At least annually and as needed:

- Administrative and operational reviews of FMSA performance, including analysis of reports provided to ADSS.

Ongoing:

- Continuous monitoring of participant feedback, satisfaction data, complaints, incident-related information, and communications between Alabama Medicaid, ADSS, and the FMSA.

Oversight Summary

These assessment methods enable Alabama Medicaid to ensure that:

- ADSS performs delegated case management functions consistent with waiver requirements;
- The FMSA, though contracted by ADSS, complies with all requirements applicable to the 1915(j) self-directed option; and
- All operational and administrative functions are performed in accordance with the TA Waiver, Alabama Medicaid

policy, and federal regulations.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete

the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMSA Data

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

	Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

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

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

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

If 'Other' is selected, specify:

Performance measure reporting tool

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

by the Medicaid Agency]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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:

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: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of 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:

Performance Measure:

Number and percent of special reports (i.e., Ad Hoc) requested by AMA and submitted by

the TCM Agency 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 TCM Agency]

Data Source (Select one):

Record reviews, on-site

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

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

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

Alabama Medicaid exercises administrative authority and responsibility of all waiver related policies, rules and regulations. Alabama Medicaid conducts meetings to disseminate policies, rules and regulations in an effort to consistently interpret the policies related to the TA Waiver program. Alabama Medicaid reviews participant files, personnel files, and home visit documentation as a method to monitor the compliance of level of care determination and appropriateness of the plan of care.

b. Methods for Remediation/Fixing Individual Problems

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

The Alabama Medicaid TA Waiver Coordinator is responsible for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Alabama Medicaid TA Waiver Coordinator is responsible for developing strategies to measure Alabama Medicaid Waiver program performance and determine how best to implement improvements. For example, the Alabama Medicaid TA Waiver Coordinator will review the annual TA Waiver Participant Satisfaction Surveys and address any concerns or feedback that is provided. Remediation for noncompliance issues and complaints identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification.

If the problem is not corrected, the entity will be monitored every three months until they are compliant. Failure to come into compliance within the timeframe specified by the Alabama Medicaid will result in the providers contract being terminated.

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

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

c. Timelines

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

☒ No

☐ Yes

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

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☒	Technology Dependent	21		☒
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age			
				Maximum Age Limit		No Maximum Age Limit	
☐ Mental Illness							
	☐	Mental Illness		☐		☐	☐
	☐	Serious Emotional Disturbance		☐		☐	

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

The TA Waiver serves adults age 21 and older who require a Nursing Facility level of care and have a medical history of being ventilator-dependent or have a tracheostomy. Participants must have a complex skilled medical condition requiring ongoing nursing intervention and oversight.

The TA Waiver target group consists of adults who:

- Are age 21 or older;
- Are financially eligible for Medicaid under one of the eligibility groups listed in Appendix B-4;
- Meet the Nursing Facility level of care criteria; and
- Require at least one TA Waiver service to avoid institutionalization.

This waiver does not serve individuals under age 21, individuals who require an ICF/IID or hospital level of care, or individuals with primary behavioral health or developmental disability support needs.

Participants must reside in a private dwelling in the community at the time of enrollment and throughout their participation in the waiver.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- **Other**

Specify:

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

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

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

- **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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	80
Year 2	80
Year 3	80
Year 4	80
Year 5	80

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 and from waiver-to-waiver.

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 and from waiver-to-waiver.

Purpose *(describe):*

The purpose of reserving slots is to assist Alabama Medicaid eligible recipients who desire to transition from nursing facilities back into the community. This reserve capacity is to ensure we have capacity to serve individuals who wish to move to the community. Also, the reserve capacity will allow individuals to transfer from another waiver because their needs can no longer be met on the waiver where they are currently receiving services.

Describe how the amount of reserved capacity was determined:

The Agency has estimated that ten slots would be the amount needed to place in reserve capacity for individuals

transitioning from the nursing facility and from waiver-to-waiver transfers.

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:

The Alabama Department of Senior Services (ADSS) utilizes a screening tool referred to as the "Referral Form". This referral form is completed for all persons seeking entry onto the waiver. This form requests personal information, current diagnoses, current benefit status, functional abilities to perform ADL's additional resources and any services currently provided to the individual in the home. Based on the information gleaned during the completion of the Referral Form, the person is prioritized for entry onto the waiver program based on assessed need. The HCBS-1 initial application is completed at the time of the initial home visit.

Alabama Medicaid enrolls participants into the TA Waiver on a first-come, first-served basis up to the waiver's approved capacity for each waiver year. Individuals may be enrolled only when:

- The applicant is determined financially eligible for Medicaid under an eligibility group included in Appendix B-4;
- The individual meets the Nursing Facility level of care criteria;
- The individual meets all target group requirements specified in Appendix B-1; and
- The TA Waiver has available capacity for the applicable waiver year.

If the waiver reaches its approved capacity, Alabama Medicaid will maintain a statewide waiting list and will enroll individuals in chronological order based on the date a completed application and level of care assessment is received, except when enrollment must be expedited to address imminent threats to a participant's health or safety.

Applicants on the waiting list are informed of their placement and updated when capacity becomes available. ADSS and Alabama Medicaid ensure that applicants who are placed on the waiting list receive information about alternative Medicaid services, including State Plan services and other HCBS programs, as applicable.

Alabama Medicaid does not use any prioritization categories, scoring systems, or subgroups in selecting entrants to the TA Waiver.

Rule No. 560-X-54-.05 Application Process

- (1) The targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community-based services.
- (2) An assessment document will be completed by the targeted case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.
- (3) The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's plan of care, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.
- (4) The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency.
- (5) Medicaid will review the medical application and determine if the individual meets the criteria for nursing facility care, in accordance with Rule No. 560-X10-.10 of the Alabama Medicaid administrative Code and submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

(a) If approved, the applicant and the targeted case manager will be notified in writing.

(b) If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14.

(6) When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

(7) A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be annually.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. **Miller Trust State.**

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

- ☐ No
- ☒ Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

iii. Allowance for the family (select one):

- ☒ Not Applicable (see instructions)

- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

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

Specify:

- **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (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

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 which includes income that is placed in a Miller Trust.

- **The following dollar amount**

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

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

Specify:

- **Other**

Specify:

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

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

Specify:

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

Specify the amount of the allowance (select one):

- **SSI standard**
- **Optional state supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

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

Specify:

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

iii. Allowance for the family (select one):

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

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

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

Specify:

- ☐ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- ☐ The following dollar amount:

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

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

Specify formula:

- ☒ Other

Specify:

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

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

Select one:

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

Explanation of difference:

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

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

Select one:

- ☒ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ **The state does not establish reasonable limits.**
- ☐ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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:

The Alabama Department of Senior Services provides targeted case management activities and conducts initial evaluations and reevaluations of the level of care of waiver participants. The Alabama Medicaid Agency determines the number of private duty nursing hours needed based upon the participant's medical condition and the assessment completed by the case manager.



Other

Specify:

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

The educational/professional qualification of individuals performing the initial evaluations are as follows:

- Bachelors of Arts degree or a Bachelor of Science degree from an accredited college or university, preferably in a human services related field, or;
- Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work, or;
- Licensed Social Worker
- Bachelor of Science in Nursing (BSN) from an accredited School of Nursing and licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with Code of Ala, Section 34-21-21.
- Physician (M.D. or D.O.)

- 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 Level of Care Criteria is defined in Alabama Administrative Code Rule No. 560-X-10-.10(2) as follows:

The TA Waiver participant must meet the nursing facility level of care. New admissions must meet two criteria. Redeterminations must also meet two criteria. The application must include supporting documentation that the participant has a medical history of being ventilator-dependent or having a tracheostomy and meets the admission criteria below:

The Admission Criteria:

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

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

If an individual meets one or more ADL within criterion (k), they must also meet an additional criterion, (a) through (j), accompanied by supporting documentation, as is currently required. Multiple items met under (k) will still count as one criterion.

Also note, criterion (a) is also the same as criterion (k) 7. Therefore, if an individual meets criterion (a), criterion (k) 7, cannot be used as the second qualifying criterion.

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

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:

The level of care evaluation is conducted according to a standardized process on all applicants for waiver services who meet admission criteria established by the AMA. The AMA has delegated the level of care determination to the Alabama Department of Senior Services (ADSS).

Once eligibility has been determined, ADSS completes a summary application page verifying eligibility. The AMA Nurse Reviewer will review the medical record to ensure the required documentation is present. The AMA will make a final determination on the participant's level of care.

The TA Waiver is the only waiver in which the AMA serves as the OA.

The process for reevaluations of LOC is the same as for initial evaluations.

Initial NF level of care evaluations are conducted by ADSS case managers under contract with Alabama Medicaid. The process includes:

- Face-to-face assessment with the applicant and, as applicable, the applicant's representative;
- Administration of the standardized NF level of care assessment tool;
- Review of medical records, physician orders, and relevant diagnostic information;
- Completion of the assessment summary, including identification of skilled nursing needs and functional limitations; and
- Submission of the completed assessment documentation to Alabama Medicaid for review.

Alabama Medicaid reviews all documentation and makes the final determination of NF level of care eligibility. Applicants are notified in writing of the decision, including information about appeal rights.

No waiver services may be initiated until Alabama Medicaid has determined that the applicant meets NF level of care and a Person-Centered Care Plan (PCCP) has been 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*):

Alabama Medicaid ensures timely annual reevaluations through an electronic tracking system that alerts ADSS case managers at 90, 60, and 30 business days before the due date. Case managers must complete reassessments and submit documentation to Alabama Medicaid no later than 15 calendar days before the expiration of the current authorization.

Alabama Medicaid monitors overdue assessments, contacts ADSS regarding any delays, and initiates corrective action when reevaluation timeliness standards are not met. Reevaluations are also required whenever a significant change in the participant's condition occurs. Participants are not disenrolled and services continue pending completion when the delay is outside their control.

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:

ADSS case managers maintain assessment records, supporting documentation, and NF level of care determinations in accordance with Alabama Medicaid policy and State record retention requirements. Records must:

- Be complete, legible, and available for review by Alabama Medicaid;
- Include assessment tools, summaries, supporting clinical information, and documentation of any significant changes;
- Be retained for the period required under State law and federal Medicaid regulations.

Alabama Medicaid maintains copies of NF level of care determination records and all related documentation necessary for oversight, quality review, and compliance monitoring.

Documentation (hard copy and/or electronic) of evaluations and re-evaluations are maintained in the following locations:

- The Alabama Medicaid Agency
- The Alabama Department of Senior Services
- The Direct Service Provider's Office
- The Case Manager's Files

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 (continues)]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Cont'd from above: that services may be needed in the future] HCBS application and enrollment data

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

HCBS application and enrollment data

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of Level of Care determination forms that were completed annually as required by the Medicaid agency. Percentage = NUMERATOR [Number of level of care determinations were completed annually as required by the Medicaid agency] / 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 =

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

	Specify: 	
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Data Aggregation and Analysis:

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

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

The AMA will work closely with the ADSS Targeted Case Manager to ensure that waiver participants are actively involved in decision-making related to the provision of waiver services and if waiver participants are encouraged to provide feedback to improve the program. The ADSS Targeted Case Manager is responsible for contacting the ADSS director about any concerns related to TA Waiver recipients. The ADSS director will notify AMA's TA waiver coordinator, if needed, to resolve any issues. In addition, the AMA TA Waiver Coordinator will review the complaints and grievance logs and asks for additional information if necessary to assure resolution within seven working days to ensure that the target dates of resolution are being met. If a decision cannot be reached, additional information is requested. Resolution is reached within seven working days from receipt of the additional information with a response disseminated to all parties involved.

When home visits are conducted by the AMA TA Waiver Coordinator is responsible for conducting interviews with the TA Waiver participants to determine their satisfaction with the services they receive and the providers rendering their services. If complaints are received outside of home visits, the AMA TA Waiver Coordinator may conduct satisfaction interviews over the phone.

b. Methods for Remediation/Fixing Individual Problems

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

The AMA TA Waiver Coordinator is responsible for developing strategies to measure the TA Waiver Program performance

and determine how best to implement improvements. For example, the AMA TA Waiver Coordinator will review the annual satisfaction surveys to determine if program changes or improvements are necessary. Re-mediation for non-compliance issues and complaints identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, depending upon the nature of the complaint, the entity will be monitored every three months or terminated from being a waiver provider.

Individual problems are discovered under the LOC assurance by notification from the case manager, review of the HCBS-1 application, and the targeted case manager's narrative summary review.

The documentation received allows the TA Waiver Coordinator to review for recurring conditions. If it is determined that a large percentage of the recipients are suffering from the same conditions, then the TA Waiver Coordinator will follow-up with the case manager to see if modifications to the program operation would be required.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services.

Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the initial contact made by the ADSS TCM, the applicant is informed of the feasible alternatives available under the waiver allowing free choice of waiver services or institutional care. Participants and/or their representative are given as much information as possible to allow them to make an informed choice based upon their individual and personal preferences without putting their health and safety at risk. This information is also provided in writing. The waiver applicant or their representative will sign the freedom of choice statement on the Admission and Evaluation Data form (HCBS-1) which serves as documentation of the individual's choice. The only exception to a written choice is when the applicant is not capable of signing the form. The reason for the absence of the signed choice form must be documented in the participant's medical record. The applicant is informed about the services available under the waiver and the scope of each service. Activities or tasks performed within each service are described in detail as well as any specific limitations within each service.

Alabama Medicaid ensures that all applicants and participants are afforded freedom of choice between receiving services through the TA Waiver or receiving Nursing Facility (NF) services under the Medicaid State Plan. At the time of application, and annually thereafter, ADSS case managers inform individuals of:

- Their right to choose waiver services instead of NF services if they meet NF level of care and all other waiver eligibility requirements;
- Their right to decline enrollment in the TA Waiver and receive NF services at any time; and
- Their right to request institutional services if they determine that community living no longer meets their needs.

Applicants and participants also have freedom to choose among all available and qualified providers of waiver services. ADSS case managers provide participants with information about all enrolled waiver providers, including options available through the Personal Choices self-directed option.

Freedom of choice is documented in the participant's record at initial assessment and at each annual PCCP review. Participants may change waiver service providers or elect to enter or transition out of the waiver at any time. No participant is restricted to a geographic area, specific provider, or provider type as a condition of receiving TA Waiver services.

If the applicant or participant is unable to provide a written acknowledgement, freedom of choice may be documented by the legally authorized representative's signature or, if no representative is available, by detailed case manager documentation of the information provided, the individual's expressed choice, and the reason a written acknowledgement could not be obtained.

Information about choice is provided in a manner that accommodates the participant's language, communication preferences, and accessibility needs.

- 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 Freedom of Choice Forms are maintained in the participant's records for a minimum of five years and are located at the following locations:

The Alabama Medicaid Agency
The Alabama Department of Senior Services

Appendix B: Participant Access and Eligibility

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

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

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

The Medicaid Agency website also contains a link to AltaVista Babel Fish Translation. This tool enables individuals with limited English proficiency to translate short passages of text or entire web sites among 19 pairs of languages. Babel Fish allows users to grasp the general intent of the original message and does not produce a polished translation.

Alabama Medicaid ensures that all applicants and participants with Limited English Proficiency (LEP) have meaningful and equal access to the TA Waiver. Access is provided in compliance with Title VI of the Civil Rights Act of 1964 and applicable federal regulations.

Language Assistance Services:

Participants with LEP receive language assistance services at no cost. These services may include:

- Oral interpretation services;
- Written translation of critical documents, including notices of eligibility, level of care determinations, and appeal rights;
- Use of bilingual staff or contracted interpreters; and
- Provision of interpreter services during assessments, PCCP development, and monitoring visits.

Language assistance services are provided in a timely manner to ensure that participation in the waiver is not delayed.

Assessment and PCCP Development:

During the application and annual reassessment process, ADSS case managers ensure that communication occurs in the participant's preferred language. Case managers identify LEP needs at intake and document the participant's language preferences in the record. Interpreter services are arranged as needed to support completion of the level of care assessment, PCCP development, and ongoing service coordination.

Notifications and Written Materials:

All written notices required under the TA Waiver—including eligibility decisions, service authorizations, PCCP updates, and fair hearing notices—are available in a translated format upon request. Alabama Medicaid ensures that individuals with LEP receive notices in a language and format they can understand, consistent with State and federal requirements.

Provider Access:

LEP status does not limit an applicant's or participant's ability to choose among qualified waiver providers. ADSS case managers assist participants in selecting providers and obtaining services in a manner consistent with their communication needs.

Ongoing Monitoring:

Alabama Medicaid and ADSS monitor access for individuals with LEP through periodic review of participant records, analysis of participant experience data, and review of language access needs identified during annual assessments or service plan monitoring. Any issues identified are addressed promptly to ensure continued compliance with federal requirements.

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	Personal Care/Attendant Services		
Extended State Plan Service	Private Duty Nursing		
Other Service	Medical Supplies		
Other Service	Pest Control Service		
Other Service	Specialized Medical Equipment		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:
Category 1:

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):

Personal Care/Attendant Services (PC/AS) provide hands-on assistance, supervision, or cueing to enable participants to accomplish activities of daily living (ADLs) and instrumental activities of daily living (IADLs) necessary to reside safely in the community.

Covered ADLs include, but are not limited to, eating, bathing, dressing, personal hygiene, toileting, transferring, ambulation, and maintaining continence.

Covered IADLs include, but are not limited to, meal preparation, light housekeeping tasks (e.g., laundry, bed-making, dusting, vacuuming), and assistance with communication (e.g., use of the telephone), when such activities are essential to the participant's health and welfare and are not performed for the convenience of the household.

Personal Care/Attendant Services may be provided in the participant's home or in community settings, including the participant's place of employment, when necessary to support the participant's independence and integration in the community.

This service includes assistance with medication self-administration, such as reminding the participant to take medications,

opening containers, or handing pre-dispensed medications to the participant. This service does not include medication administration or other skilled nursing tasks.

Personal Care/Attendant Services do not include services that are duplicative of other Medicaid State Plan or waiver services, including but not limited to skilled nursing, therapy services, or home health aide services.

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

The amount, frequency, and duration of Personal Care/Attendant Services are determined based on the participant's assessed needs and are authorized in the Person-Centered Care Plan (PCCP).

Services are billed in 15-minute units. Authorized units must be specified in the Service Authorization and reflect the minimum number of hours necessary to safely meet the participant's needs.

Reimbursement does not include time spent traveling to or from the participant's residence or community location, nor time associated with worker breaks or meals.

Personal Care/Attendant Services may be provided in conjunction with employment; however, services must be limited to assistance with ADLs and IADLs and may not include vocational training, job coaching, or tasks that are the responsibility of the employer.

Under the 1915(j) authority, participants may self-direct this service. Self-directed workers may include relatives, legally responsible persons, or legal guardians, consistent with waiver requirements and as specified in Appendix E. All self-directed workers must meet applicable qualification, background check, and training requirements prior to providing 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 Health/Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care/Attendant Services

Provider Category:

Individual

Provider Type:

Personal Choices- Self-Directed Workers

Provider Qualifications

License (specify):

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

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

Self-directed workers must:

- Be at least 18 years of age;
- Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;
- Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;
- If providing transportation, possess a valid driver's license and insurance as required by state law;
- Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

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

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

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

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

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

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

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

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

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

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

Service Type: Statutory Service

Service Name: Personal Care/Attendant Services

Provider Category:

Agency

Provider Type:

Home Health/Home Care Agency

Provider Qualifications

License (specify):

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

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

Certificate (specify):

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

Other Standard (specify):

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

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

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Medicaid Agency

Frequency of Verification:

Upon initial approval and annually by Alabama Medicaid 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:

Extended State Plan Service

Service Title:

Private Duty Nursing

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):

Private Duty Nursing (PDN) is a service that provides skilled medical observation and nursing services performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in accordance with the Alabama Nurse Practice Act and Alabama State Board of Nursing requirements.

Private Duty Nursing includes continuous, individualized skilled nursing services necessary to address complex medical needs requiring ongoing assessment, monitoring, and intervention by a licensed nurse under physician orders.

Services may include, but are not limited to:

Skilled nursing assessment and monitoring of the participant's condition;
 Administration of medications and treatments;
 Management of medical equipment and technology, including ventilators, feeding tubes, and other life-sustaining interventions;
 Observation and documentation of changes in the participant's condition;
 Implementation of nursing interventions to maintain health and prevent complications.

Private Duty Nursing services are based on the individual participant's assessed needs and must be authorized in the Person-Centered Care Plan (PCCP).

Private Duty Nursing under the waiver does not duplicate skilled nursing services available under the mandatory home health benefit in the Medicaid State Plan. When participants are eligible for State Plan home health services, coordination occurs to ensure services are utilized appropriately and are not duplicative.

Private Duty Nursing services are provided based on medical necessity and are authorized in accordance with the participant's Person-Centered Care Plan (PCCP).

Private Duty Nursing is distinguished from Personal Care/Attendant Services in that it involves the provision of skilled nursing tasks requiring clinical judgment and licensure.

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

The amount, frequency, and duration of Private Duty Nursing services are based on medical necessity and are authorized in the Person-Centered Care Plan (PCCP) and Service Authorization.

Services are billed in one-hour units. Authorized units must reflect the participant's assessed medical needs and be supported by physician orders and clinical documentation.

Private Duty Nursing services are limited to a maximum of 12 hours per day per participant, unless additional hours are authorized by Alabama Medicaid based on documented medical necessity.

Additional hours may be authorized for up to 90 days under the following circumstances:

Immediately following hospital discharge while a caregiver is being trained;
 During acute episodes requiring increased skilled monitoring;
 When an alternate caregiver is unavailable;
 When the primary caregiver is temporarily unable to provide care; or
 When Alabama Medicaid determines additional hours are medically necessary based on clinical review.

Requests for services exceeding 12 hours per day are subject to review at least every 30 days.

Reimbursement does not include transportation time or time associated with nurse breaks or meals.

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	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License (*specify*):

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

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

Certificate (*specify*):

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

Other Standard (specify):

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

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

- All staff must meet background check requirements, including abuse registry, sex offender registry, and exclusion checks;
- Nursing services must be delivered by qualified RNs or LPNs (two years experience preferred), with LPN services provided under RN supervision in accordance with state law;
- Must be at least 18 years of age;
- Must have references which are verified and documented; and
- Must be able to read and write and understand instructions.

All Private Duty Nurses must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Medicaid

Frequency of Verification:

Annual Personnel Record Review

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:

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, or such other non-durable medical equipment not otherwise available under the state plan that is necessary to address participant functional limitations; and, necessary medical supplies not available under the state plan.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

All items 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 or other licensed practitioner acting within the scope of state law.

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

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

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

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 \$6,000.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

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	Durable Medical Equipment Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

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

Medical Supplies may be furnished by providers that are enrolled with Alabama Medicaid and authorized to supply medical equipment or supplies, including but not limited to durable medical equipment (DME) suppliers, pharmacies, and other qualified vendors that meet applicable federal and state requirements.

Providers must:

- Be properly enrolled as a Medicaid provider for the applicable category of medical supplies furnished;
- Comply with all applicable federal and state laws and regulations governing the manufacture, distribution, and provision of medical supplies;
- Maintain documentation sufficient to demonstrate that supplies furnished are ordered by a physician or other licensed practitioner acting within the scope of state law.

Code of Alabama, 1975, 34-14-C-3

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Medicaid

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:

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:

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

Pest Control services include the following activities:

- assessment or inspection
- application of chemical-based pesticide
- 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	Licensed and Certified 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:

Licensed and Certified Pest Control Company

Provider Qualifications

License (*specify*):

State of AL business License

Certificate (*specify*):

Code of Alabama, 1975, § 40-12-40

Other Standard (*specify*):

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:

Specialized Medical Equipment

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):

Specialized Medical Equipment is provided to support participants in maintaining independence, improving functional capacity, and ensuring health and safety in the home and community setting. This service may also be used to prevent institutionalization or to facilitate transition from an institutional setting to the community.

Specialized medical equipment and supplies include:

- (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
- (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
- (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and
- (e) necessary medical supplies not available under the state plan.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation.

In addition, this service includes activities necessary to support the selection, acquisition, or use of Specialized Medical Equipment, including evaluation, customization, fitting, adaptation, maintenance, repair, and training in the use of the equipment.

All items must be:

Medically necessary;

Prescribed by a physician or other licensed practitioner acting within the scope of state law; and

Specified in the participant's Person-Centered Care Plan (PCCP).

Supplies provided under this service are limited to those necessary for the operation of Specialized Medical Equipment and do not include general medical or personal supplies available under other services.

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

The Specialized Medical Equipment item must be ordered by a physician, documented on the PCCP and must be prior authorized and approved by the Alabama Medicaid Agency or its designee.

To obtain prior authorization for the service, the Case Manager must submit a copy of the following documents:

1. An agreement between the Alabama Medicaid and the company providing the service;
2. A price quotation list from the company supplying the equipment, providing a description of the item;
3. A legible copy of the physician's prescription for the item; and

Note: The case manager must inform providers that they have to submit the Medicaid Prior Authorization Form (Form #342) to the TA waiver nurse reviewer for approval.

Upon completion of service delivery, the participant must sign and date acknowledging that they are satisfied with the service. Providers of assistive technology shall be capable of supplying, maintaining and training in the use of specialized medical equipment devices.

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	Vendor with a Business license

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Vendor with a Business license

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

Providers of Specialized Medical Equipment under the TA Waiver must have a signed provider agreement with the Alabama Medicaid.

Specialized Medical Equipment may be furnished by providers enrolled with Alabama Medicaid and authorized to supply assistive technology devices, equipment, or services, including but not limited to durable medical equipment suppliers, rehabilitation technology providers, and other qualified vendors that meet applicable federal and state requirements.

Providers must:

- Be properly enrolled as a Medicaid provider for the applicable category of specialized medical equipment furnished;
- Comply with all applicable federal and state laws governing the manufacture, distribution, and provision of specialized medical equipment devices and equipment; and
- Furnish specialized medical equipment ordered by a physician or other licensed practitioner acting within the scope of state law, when required.

Code of Alabama, 1975, 34-14-C-3

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

Alabama Medicaid

Frequency of Verification:

Initially then Annually

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

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

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

Check each that applies:

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

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

The Alabama Department of Senior Services provides targeted case management activities to participants of the Technology Assisted Waiver for Adults.

ADSS ensures that all Targeted Case Managers receive New Case Manager training on Home and Community-Based Services (HCBS) inclusive of HCBS Settings Rule requirements and Person Centered Thinking Training on person-centered planning regulations. Training includes instruction on:

- Participant rights, dignity, autonomy, and community integration;
- Person-centered planning requirements at 42 CFR §441.725;
- Development and monitoring of the PCCP;
- Identifying and addressing risks to health and safety;
- Supporting participant choice and control.

Case Managers receive this training at initial hire and at least annually thereafter, with additional training provided when federal or state requirements are updated. ADSS documents completion of required training and provides ongoing technical assistance to ensure continued compliance.

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

No services selected for remote delivery

Appendix C: Participant Services

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

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

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

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

All positions that provide waiver services or have direct or indirect contact with TA Waiver participants, including registered nurses (RN), licensed practical nurses (LPN), personal care workers, case managers, and office staff with participant contact, are required to undergo background investigations.

The scope of the background investigation is nationwide. Each direct service provider (DSP) selects a qualified vendor to conduct the background investigation. For individuals who self-direct services, nationwide background checks are conducted by the Financial Management Services Agency (FMSA) and include reference checks with previous employers, review of the sex offender registry, and verification through the Nurse Aide Registry, as applicable.

The Alabama Medicaid Agency ensures compliance with background investigation requirements through annual provider audits conducted by the Alabama Medicaid Quality Assurance Nurse.

As part of this review, the Alabama Medicaid Quality Assurance Nurse conducts a 100 percent review of personnel records for all staff with direct or indirect contact with TA Waiver participants to verify that required criminal history and background investigations have been completed.

For nursing staff providing private duty nursing services, the Alabama Medicaid Quality Assurance Nurse verifies that:

- Required background investigations have been conducted; and
- Nursing licenses are current and active.

Because the Alabama Board of Nursing (ABN) discontinued issuing physical license cards effective July 5, 2016, verification is obtained through primary source verification, including the ABN License Lookup system, ABN Subscription Service, or official verification available through the ABN website.

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

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

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

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state

and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

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

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

The State permits payment to legally liable relatives for the provision of personal care services when such services constitute extraordinary care that exceeds the ordinary care that would be provided to a person without a disability or chronic illness of the same age and when necessary to assure the health and welfare of the participant and to avoid institutionalization.

a. Types of legally liable relatives who may be paid

Payment may be made to legally liable relatives as defined under state law, including:

- A spouse of the participant; and
- A parent of an adult participant, when applicable under state law.

b. Waiver services for which payment may be made

Payment to legally liable relatives may be authorized only for the following waiver service when provided as extraordinary care:

Personal Care/Attendant Service

This service is non-skilled in nature and fall within the scope of personal care or similar services. Payment is not authorized for any other waiver services under this provision.

c. Determination of “extraordinary care”

The State distinguishes extraordinary care from ordinary care through the person-centered care planning and assessment process. Extraordinary care is defined as assistance with activities of daily living (ADLs) that:

- Exceed what would ordinarily be expected of a legally liable relative for a person of the same age without a disability or chronic illness; and
- Are required to meet the participant’s assessed functional needs, ensure health and welfare, and prevent institutional placement.

The determination of extraordinary care is documented in the Person-Centered Care Plan (PCCP) and supported by assessment findings and service justification.

d. Best interest determination

The State ensures that payment to a legally liable relative is in the best interests of the participant through:

- A person-centered planning process that prioritizes the participant’s preferences, needs, and outcomes;
- Consideration of the availability of other qualified providers;
- Documentation that the arrangement supports the participant’s health, welfare, and community living goals; and
- Ongoing monitoring by the case manager to ensure services are delivered appropriately and effectively.

e. Substituted judgment

When a legally liable relative has decision-making authority over the selection of waiver service providers, the State ensures substituted judgment is used through:

- Case manager facilitation of the person-centered planning process;
- Documentation that service decisions reflect the participant’s preferences, values, and expressed goals to the greatest extent possible; and
- Oversight and review during service plan development, updates, and monitoring contacts.

f. Limitations on authorization and amount

Payment to legally liable relatives is subject to the following limitations:

Payment is authorized only for services identified in the approved PCCP;
 Payment is limited to the amount, scope, frequency, and duration specified in the service plan;
 Payment is not authorized for services that duplicate informal supports or ordinary spousal or familial responsibilities; and
 All services must meet waiver service definitions and requirements.

g. Additional safeguards

Additional safeguards implemented by the State include:

Verification that the legally liable relative meets all applicable provider qualifications;
 Execution of a valid provider agreement prior to service delivery;
 Documentation of participant choice and informed consent;
 Monitoring of service delivery through regular case management contacts; and
 Review of potential conflicts of interest as part of service plan development and oversight.

h. Oversight and payment controls

The State ensures payment is made only for services rendered through:

Verification that services are authorized in the PCCP;
 Review of service documentation and billing records;
 Comparison of service delivery records with authorized services;
 Ongoing monitoring by case managers; and
 Administrative and audit oversight conducted by the Alabama Medicaid Agency.

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

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

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

☒ **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:

Alabama Medicaid maintains continuous, open enrollment for all willing and qualified providers of TA Waiver services. Providers who meet the qualifications specified in Appendix C-3 may enroll at any time and are not restricted to specific enrollment periods.

Provider enrollment information, requirements, and forms are available through Alabama Medicaid's website and through the State's fiscal agent, Gainwell Technologies, ensuring that all interested providers have ready access to participation requirements.

Medicaid's fiscal agent, Gainwell, enrolls private duty nursing, home health, and durable medical equipment providers and issues provider agreements to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

All willing and qualified providers may request enrollment as TA Waiver providers at any time. Requests for participation in the TA Waiver are processed by Alabama Medicaid without restriction, and qualified providers are enrolled upon verification of applicable provider qualifications and program requirements.

As part of the enrollment process, the Alabama Medicaid Program Integrity Division reviews provider applications to ensure compliance with applicable requirements. Upon approval, the TA Waiver service is added to the provider's enrollment file, and the provider is authorized to begin furnishing services to TA Waiver participants.

The enrollment process is completed within established Medicaid provider enrollment timeframes, generally within ten business days following receipt of all required documentation.

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 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/cert standards and other standards established by AMA]/ DENOMINATOR [Number of existing licensed/cert contracted providers]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification Surveys

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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 cert. standards, other standards est. by AMA, etc.]/ DENOMINATOR[All new licensed/cert. contracted providers]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Initial Certification Surveys

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

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

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Data Aggregation and Analysis:

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

Performance Measure:

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

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

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Training verification records; New Employee Enrollment packet

Responsible Party for data collection/generation (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: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of providers that meet training requirements in accordance with state requirements and the approved waiver. Percentage = NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver] / DENOMINATOR [Number of providers who require training]

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 enrolled self-directed employees who continue to meet waiver training requirements. Percentage = NUMERATOR [Number of currently enrolled self-directed employees that continue to meet waiver training requirements]/ DENOMINATOR [Number of currently enrolled self-directed employees]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Training verification records

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

AMA conducts annual onsite visits to ADSS as the targeted case management provider to evaluate provider training, service planning, provider qualification, safeguards, consumer satisfaction and monitor compliance with policies and procedures as well as the waiver document requirements. AMA TA Waiver Coordinator and ADSS Targeted Case Manager will meet to discuss identified problems or issues annually. Throughout the year, the ADSS Targeted Case Manager and AMA TA Waiver Coordinator contact each other either via telephone or e-mail to discuss problems that may require an immediate response or an update on the recipients medical condition.

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.

During annual audits of DSPs, the TA Waiver Coordinator shall review records to ensure that the DSP is in compliance with current licensure and certification standards. The TA Waiver Coordinator also verifies that provider training has been conducted according to the waiver document.

The TA Waiver Coordinator is responsible for the discovery and remediation activities. If there are any deficiencies that are discovered during the audit, training and education are initiated while on site. If there is gross deficient practice observed, a deficiency will be leveraged and a plan of correction will be requested from the DSP. A letter will be sent by email and certified mail to include the deficient practice and a 15 day deadline to submit a plan of correction. The TA Waiver Coordinator shall assess that the plan of correction was initiated and actively being followed during the DSP's annual on-site audit.

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

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

c. Timelines

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

☒ No

☐ Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

- ☐ **Other Type of Limit.** The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

Waiver services under the Technology Assisted (TA) Waiver for Adults are delivered exclusively in home and community-based settings that comply with the requirements at 42 CFR § 441.301(c)(4)–(5).

Participants receive services in the following setting types:

1. Private Residences

- The participant's own home or an apartment they lease or own.
- These settings are not provider-owned or controlled.
- Participants have full autonomy over daily schedules, visitors, meals, furnishings, and personal resources.

2. Family Homes

- The home of a family member with whom the participant chooses to reside.
- These environments afford full access to community life and do not restrict choice of providers or services.

3. Community Locations

- Places in the community where the participant engages in activities included in the PCCP (e.g., medical appointments, errands, social activities).
- These are non-disability-specific locations integrated within the broader community.

No TA waiver services are delivered in provider-owned or controlled residential settings, congregate facilities, or settings that isolate individuals from the broader community.

No settings under this waiver fall under the categories presumed to be institutional (e.g., settings on the grounds of a public institution, inpatient treatment facilities, or settings with isolating characteristics).

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.)*

Alabama Medicaid ensures that all settings in which TA waiver services are delivered comply with 42 CFR § 441.301(c)(4)–(5) at the time of this submission and on an ongoing basis. The TA Waiver serves participants exclusively in private homes and community settings, which meet HCBS criteria when individualized rights, autonomy, and community access are upheld.

The State assesses and monitors settings through the following processes:

1. Initial Assessment of HCBS Settings Compliance

During the waiver enrollment process, the ADSS Targeted Case Manager conducts an in-home assessment to confirm that the participant's residence meets HCBS settings criteria, including privacy, autonomy, community integration, freedom from coercion, and individual choice of providers.

The case manager documents HCBS compliance in the Person-Centered Care Plan (PCCP).

If concerns are identified, Alabama Medicaid conducts further review and remediation before authorizing services.

2. Ongoing Monitoring of HCBS Settings

Alabama Medicaid and ADSS ensure continued compliance through:

Monthly in-person visits by the Targeted Case Manager to confirm continued HCBS adherence, including participant choice, autonomy, and access to the community.

Annual reassessments of the PCCP with review of HCBS criteria.

Quality Assurance Nurse reviews, including home visits when indicated, record reviews, and validation of participant rights and provider practices.

Complaint and incident reviews to identify any potential rights violations or restrictive practices inconsistent with HCBS standards.

Participant satisfaction surveys assessing autonomy, privacy, access to community life, and choice of services/providers.

Provider monitoring and credentialing reviews, ensuring provider practices do not restrict participant rights or autonomy.

3. Remediation and Corrective Action

If a potential HCBS settings compliance issue is identified, Alabama Medicaid and ADSS:

Document the issue and its impact on HCBS compliance.

Develop a corrective action plan with the provider or case management entity.

Conduct follow-up monitoring to verify remediation.

May suspend or terminate provider participation if compliance is not restored.

4. Ongoing State Oversight

Alabama Medicaid compiles monitoring data, including:

Case management visit findings

Provider reviews

Incident reports

Participant feedback

This information is analyzed to:

Identify systemic trends

Address areas needing training or corrective action

Ensure all settings remain compliant during the waiver cycle

Because the TA Waiver serves adults in non-provider-owned residential settings, no heightened scrutiny determinations are required.

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

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:

The case manager must meet the following educational requirements:

Bachelors of Arts Degree or a Bachelor of Science Degree from an accredited college or university, preferably in a human services related field, or;

● Bachelor of Arts Degree or a Bachelor from an accredited School of Social Work, or;

● Bachelor of Science Degree in Nursing (BSN) from an accredited School of Nursing, licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with Code of Ala., 1975 34-21-21.

Note: All case managers must have an initial tuberculosis (TB) Skin Test, then a tuberculosis (TB) screening annually.

- ☐ **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.

ADSS case managers support participants in the service planning process by:

- Explaining the PCCP process and their rights to direct planning decisions;
- Assisting participants to identify goals, preferences, strengths, and desired outcomes;
- Providing information about available waiver services, qualified providers, and the Personal Choices self-directed option;
- Ensuring participants understand risks and benefits of service options; and
- Arranging for interpreters or accessible materials when needed.

Participants may request assistance from a representative of their choosing. Case managers ensure that participants receive the information and support necessary to make informed decisions. The Targeted Case Manager, the participant and/or a family of legal representative or other persons designated by the participant will all meet to develop the Person Centered Care Plan (PCCP). The meeting is scheduled between all involved parties at an agreed upon time in the participant's home. During the meeting all parties will discuss the needs of the participant, informal supports provided by family or other community resources, identify the gaps in supports, and are informed by the Targeted Case Manager of waiver services which may fill those gaps. The participant decides which personal representative will be involved in development of the Person Centered Care Plan. Development of the Person Centered Care Plan should include participation by the participant, the participant's family/sponsor, and Targeted Case Manager. This process will provide information for all individuals to make informed choices regarding available community services and support. Informal supports are crucial in supplementing the Person Centered Care Plan. 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.

Developing a Person Centered Care Plan will include a comprehensive review of the participant's problems, strengths and weaknesses. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development includes participation by the participant and/or family/primary caregiver, and Targeted Case Manager. The PCCP development process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized. Development of the PCCP for all individuals applying for the TA Waiver is based on individual needs.

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. All services needed by the participant will be included in the PCCP implemented by the Targeted Case Manager. Development of the PCCP for all participants transitioning from the institution is based on individual needs. Development of the PCCP should include participation by the participant, the participants family/sponsor, and Targeted 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 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.

Service Coordination will be accomplished by the Targeted 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 Targeted 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. Each case will be monitored monthly through contacts and at least one face-to-face visit monthly with the participant. Special emphasis will be put on discussion of the 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.

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 (PCCP) is developed collaboratively with the participant, Targeted Case Manager, family or legal representative, and other persons designated by the participant before initiation of waiver services. 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 changes. The Targeted Case Manager will schedule a meeting with all interested parties to secure information about the participant's needs, preferences, goals, other non-waiver services or community supports. The Targeted 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 all of the 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. PCCP's are individualized for each participant and seek to balance the participant's rights, values and preferences.

Non-waiver services and community supports are a crucial part of the PCCP development. Waiver services are not permitted to be provided 24/7, therefore non-waiver services are needed to ensure an individual's health and safety. 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 Targeted 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 Targeted Case Manager will review the PCCP with the participant, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are identified by the Targeted Case Manager, to be approved by the operating agency and 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 waiver services necessitates authorization from the operating agency and 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.

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

- ☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**
- ☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**
 - ☐ **A specific and individualized assessed need for the modification.**
 - ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
 - ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
 - ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
 - ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
 - ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be**

terminated.

☐ Informed consent of the individual.

☐ An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Potential risks to participant's safety are addressed in the development of the Person Centered Care Plan (PCCP). Plans are individualized and take into consideration participant's rights, values, preferences, and desired level of autonomy as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed and the PCCP is adjusted accordingly and evaluated for appropriateness. The participant directs the selection of risk mitigation strategies to the extent possible. During the monthly visit, the Targeted 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 Targeted Case Manager also documents, addresses and monitors any health and safety concerns. Additionally, 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 Targeted Case Manager and in writing to the supervisor at the DSP agency. Waiver applicant or participants are also informed of procedures necessary to file a formal complaint or grievance regarding availability, deliver or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility.

When the participant is considered at "high" risk, the Targeted Case Manager may visit more often to monitor the situation to ensure the participant's health and safety is not jeopardized. "High Risk" participants are participants who are totally dependent on waiver and/or non-waiver services for their daily care needs. These participants' backup plan is vital to their health and safety. When there is a situation that delays or prohibits services being delivered, this participant will have to use their backup plan to satisfy their health and safety needs. Situations which may affect the delivery of services are: (but not limited to) weather emergencies, natural disasters, missed visits from the DSP, and participants who have highly complicated medical needs. When a risk has been reported or identified, a home visit to monitor the health and safety of the participant is required as soon as it can be arranged. Targeted Case Managers will review and modify the PCCP if necessary to address the concerns.

The targeted case manager, participant, and/or representative discuss all identified risks. Prior to initiating a PCCP update, the case manager must contact the provider to determine the start date and discuss any special needs to the client. 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 develop an Emergency Disaster Plan. The emergency/disaster priority status is entered on the PCCP 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:

- 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.)
- Priority, Client 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. Back up plans may include priority notification at fire department and emergency management services.)
- Priority, Advanced Medical Need - Client has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Client is on ventilator, dialysis, or other specialized equipment/service. Back up plans may include priority electrical restoration service or priority notification at fire department and emergency management services.)

These plans are reviewed at least annually and updated whenever participant needs or circumstances change.

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.

Participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the person centered care plan as follows:

On the initial visit, the targeted case manager provides the participant with a list of providers (listed in alphabetical order) for all waiver services available in the area, including the right to self-direct services through the Personal Choices program. During this visit a written choice is made for each waiver service the participant desires to access at the time. The participant and/or responsible party is encouraged to choose at least three providers if more than two providers are available for the chosen service, and prioritize the choices by numbering them "1", "2", and "3." The list of providers provided to the participant by the case manager must be enrolled as being a TA Waiver provider.

Participants are informed of their right to change providers at any time. If subsequent changes or additions of providers are made verbally they are documented in the case narrative or as a case note. A copy of an updated list of providers is given to participants at each redetermination visit so that the participant will always be informed of providers serving the area.

Participants are also advised of their freedom to select a provider that is not on this list as long as the provider meets the provider qualifications for the specific services included on the Person Centered Care Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Alabama Medicaid Agency TA Waiver Coordinator or their designee conducts a review of 100% of the Person Centered Care Plans (PCCP) and related documents prior to participants receiving services during initial enrollment and annually. The review ensures that participants receiving services under the waiver have a PCCP in effect for the period of time the services are provided. This also ensures that the need for services is documented in the PCCP and that all service needs are addressed in the PCCP prior to service delivery.

Alabama Medicaid authorizes all waiver services and ensures the PCCP:

- Is person-centered and consistent with assessed needs;
- Reflects NF level of care requirements;
- Addresses identified health and safety risks;
- Includes only services necessary to support community living; and
- Meets all federal and state requirements.

No waiver services may begin until Alabama Medicaid issues approval.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

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

- ☒ **Medicaid agency**
☐ **Operating agency**
☒ **Case manager**
☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) Entity Responsible

The Targeted Case Manager is responsible for monitoring the implementation of the Person-Centered Care Plan (PCCP), participant health and welfare, and adherence to HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5).

Providers are responsible for delivering services in accordance with the PCCP and for reporting concerns related to participant health, safety, or service delivery to the Targeted Case Manager.

The Alabama Medicaid Agency provides oversight through quality assurance and review activities, including review of Targeted Case Management records, participant records, and other monitoring processes.

(b) Monitoring and Follow-Up Methods

Monitoring is conducted through ongoing contact with the participant and review of service delivery to ensure that services are furnished in accordance with the approved PCCP.

Monitoring activities include:

Verification that services are delivered as authorized, including type, scope, amount, duration, and frequency;
 Assessment of the participant's health status, functional needs, and overall well-being;
 Evaluation of the effectiveness and appropriateness of services in meeting the participant's goals;
 Confirmation that formal and informal supports identified in the PCCP are available and sufficient to maintain the participant's health and safety; and
 Identification of gaps in services or emerging risks.

The Targeted Case Manager initiates follow-up actions as needed, including coordination with providers, revision of the PCCP, or changes to service providers to ensure participant needs are met.

Critical incidents are reported, reviewed, and resolved in accordance with the waiver's incident management system described in Appendix G.

(c) Frequency of Monitoring

Monitoring is conducted at least monthly and includes a minimum of one face-to-face visit with the participant each month. Additional monitoring contacts occur as needed based on the participant's needs, changes in condition, or identified risks.

The PCCP is reviewed at least every 60 days and updated as necessary to reflect changes in the participant's needs, preferences, or circumstances.

The Alabama Medicaid Agency conducts ongoing oversight through periodic reviews and quality assurance activities, including annual reviews and additional monitoring as warranted based on identified risk, complaints, or quality concerns.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. By checking each box, the state attests to having a process in place to ensure:

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other	☐ 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 participants whose service plans address all of the participant's personal goals. Percentage = NUMERATOR [Number of participants who have all of the participant's personal goals addressed in the service plan] / DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant record reviews, on-site (Certification) i.e., Participants' Assessment Forms and person-centered service plans (PCCP))

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of 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, 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% 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, 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
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

Performance Measures

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

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

Performance Measure:

Number and percent of 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% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

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

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

If 'Other' is selected, specify:

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

		Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of 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, 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:	

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Data Aggregation and Analysis:

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

If 'Other' is selected, specify:

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

		Confidence Interval = 95% confidence level with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of 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, 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:	

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Data Aggregation and Analysis:

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

If 'Other' is selected, specify:

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

		Confidence Interval = 95% confidence level with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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 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 records.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Participant Record reviews on-site (Certification); Claims data (MMIS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of 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, off-site**

If 'Other' is selected, specify:

Participant Record reviews on-site (Certification); Claims data (MMIS)

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

Data Aggregation and Analysis:

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

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:

Participant Record reviews on-site (Certification); Claims data (MMIS)

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

	Ongoing	Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participants that answered "yes, all services" to being able to choose or change what kind of services they received. Percentage = NUMERATOR [Number of participants that answered "yes, all services" to being able to choose or change what kind of services they received] / DENOMINATOR [Number of participants interviewed]

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

If 'Other' is selected, specify:

Participant interviews, on-site (Certification)

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

Data Aggregation and Analysis:

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

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

e. Sub-assurance: *The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Participant interviews, on-site (Certification)

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

		Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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, 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
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

The AMA TA Waiver Coordinator conducts 100% record reviews during the initial approval process. In addition the AMA TA Waiver Coordinator reviews redeterminations annually to determine if participants were afforded choice between institutional and community services, as well as, choice between direct service providers.

The state shall ensure each sub-assurance related to participant surveys are statistically valid by changing to a 95% confidence level, +/- a 5% margin of error, and a 50% response distribution.

b. Methods for Remediation/Fixing Individual Problems

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

The Medicaid Agency staff, the ADSS Targeted Case Manager and the Director of the Alabama Department of Senior Services meet regularly to discuss the TA Waiver general operations. If there are particular trends, changes to policy and procedures will ensue to accommodate the needs of the waiver population.

As individual problems arise, decisions are made as a cooperative effort between the Targeted Case Manager, the ADSS Director, and the TA Waiver Coordinator. The population of this waiver is small and unique and each problem can be addressed individually to a satisfactory outcome.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
☒ Other Specify: ADSS TCM provider.	☐ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix E: Participant Direction of Services

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

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Nature of the opportunities afforded to participants

Alabama Medicaid offers participant direction through the State's approved 1915(j) Personal Choices Program, which operates concurrently with the TA Waiver. The Personal Choices Program allows participants to exercise employer and budget authority for Personal Care/Attendant Services as defined under the 1915(j) State Plan authority. The TA Waiver does not include self-directed services under the 1915(c) authority; instead, participants may elect to self-direct services through the Personal Choices Program in accordance with the approved 1915(j) State Plan Amendment.

Participants are afforded the opportunity to direct their services by choosing between traditional agency-based service delivery and the Personal Choices self-directed option when Personal Care/Attendant service included in the Person-Centered Care Plan (PCCP). This option is available statewide. Participants who elect the Personal Choices option assume the role of employer of record and are responsible for selecting, hiring, training, and supervising their workers. Participants who are unable to manage these responsibilities may appoint a representative to act on their behalf. Representatives may not be paid workers and must be free of conflict of interest. The appointment of a representative is reviewed and approved by the Case Manager to ensure appropriateness.

(b) How participants may take advantage of these opportunities

The Case Manager provides information during the person-centered planning process to ensure that participants and their caregivers are able to make informed choices regarding participation in the Personal Choices Program. When Personal Care/ Attendant service is identified in the PCCP, participants are offered a choice between traditional provider-managed services and the self-directed Personal Choices option.

Participants who elect to self-direct may manage their own services or appoint a representative to assist them. The selection of the self-directed option, as well as the designation of a representative if applicable, is documented in the PCCP. The PCCP reflects the participant's decision to self-direct services and incorporates all necessary supports, including State Plan services, waiver services, natural supports, and risk mitigation strategies.

(c) Entities that support individuals who direct their services and the supports that they provide

Participants who elect to self-direct receive support from the Case Manager, a Personal Choices Counselor, and a Financial Management Services Agency (FMSA).

The Case Manager is responsible for overall service planning, coordination, and monitoring, including ensuring that services are delivered in accordance with the PCCP and that participant health and welfare needs are met.

The Personal Choices Counselor provides orientation and ongoing support to participants, including education regarding employer responsibilities and assistance with managing self-directed services.

The FMSA functions as a fiscal intermediary and supports participants in carrying out employer-related responsibilities. The FMSA assists with worker enrollment, conducts required background screenings consistent with State policy, processes payroll, withholds and files applicable taxes, and tracks service utilization against the approved service plan and budget. The FMSA also reports any identified issues to the Case Manager and Alabama Medicaid. The participant, or their representative, is responsible for reviewing and approving worker timesheets prior to submission to the FMSA. The FMSA processes payments only for authorized services and maintains documentation to support all expenditures.

(d) Other relevant information about the waiver's approach to participant direction

Risk management strategies, including backup plans and identification of critical supports, are incorporated into the PCCP to ensure continuity of services. The Case Manager conducts ongoing monitoring, including regular contact with the participant, to ensure that services are delivered as authorized and that participant health and welfare needs are met.

Alabama Medicaid maintains oversight of the Personal Choices Program through monitoring of FMSA performance, review of quality and utilization data, and participant feedback activities. This oversight ensures compliance with program requirements and supports continuous quality improvement.

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

The waiver is designed to offer participants (or their representatives) the opportunity to direct some services through the State's approved 1915(j) Personal Choices Program. Participants who elect this option may self-direct Personal Care and Personal Assistance services, as applicable.

At the time of application, redetermination, and upon request, the Case Manager informs the participant of the option to self-direct services through the Personal Choices Program. Participants may choose to manage their own services or appoint a representative to assist them. The election to self-direct is voluntary and is not contingent upon assessment findings.

Participants who elect to self-direct may hire qualified individuals, including legally liable relatives, in accordance with the policies and safeguards described in Appendix C-2-d and C-2-e. All providers, including relatives, must meet applicable provider qualifications and enrollment requirements.

Participants who choose not to self-direct, or who discontinue participation in the Personal Choices Program, will receive services through traditional provider-managed service delivery. The Case Manager ensures that all participants have access to necessary services regardless of their election.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

(a) Information provided to the participant

Participants are provided information regarding the opportunity to self-direct services through the Personal Choices Program to support informed decision-making. Information includes:

- An explanation of participant direction and the Personal Choices Program
- The services available for self-direction
- The differences between agency-delivered and self-directed services
- Participant rights and responsibilities, including employer and budget authority
- Potential risks and liabilities associated with self-direction
- Available supports, including the roles of the Case Manager, Personal Choices Counselor, and Financial Management Services Agency (FMSA)
- The option to hire qualified workers, including legally liable relatives, in accordance with State policy
- The participant's right to decline or discontinue self-direction at any time

As part of the orientation process, participants are provided and guided through the following tools:

- A Rights and Responsibilities agreement outlining participant roles and obligations
- A Self-Assessment to evaluate the participant's ability to manage employer responsibilities
- A Risk Assessment Checklist used to identify potential risks and develop mitigation strategies
- A participant handbook that describes program requirements, roles, responsibilities, and available supports

Participants also develop a Personal Support Plan, which identifies additional resources, backup supports, and strategies to address identified risks.

(b) Entities responsible for furnishing information

The Case Manager and the Personal Choices Counselor are responsible for furnishing information regarding participant direction.

The Case Manager introduces the option of self-direction during the person-centered planning process and ensures the participant has sufficient information to make an informed choice. The Personal Choices Counselor provides detailed orientation and ongoing education related to participant direction, including employer responsibilities, risk management, and use of program tools.

(c) How and when information is provided

Information regarding participant direction is provided at multiple points to ensure timely and informed decision-making, including:

- At the time of application
- During the person-centered planning process
- At redetermination
- Upon participant request
- During enrollment into the Personal Choices Program

Following the participant's election to self-direct, the Personal Choices Counselor conducts a comprehensive orientation prior to the initiation of services. This orientation includes review of all required materials and completion of assessment and risk management tools.

Information is provided in a manner that supports participant understanding and informed choice. The timing of orientation and enrollment activities may vary based on participant preference, but all required information is provided prior to the start of self-directed services.

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:

The state provides for the direction of services by a participant-appointed representative when the participant is unable or chooses not to manage employer and budget authority independently.

If the participant elects to participate in the 1915(j) Personal Choices Program, the participant may manage their own services or appoint a representative to act on their behalf. The representative may be a non-legal individual freely chosen by the participant, such as a family member or other trusted individual.

Representatives may not be employed by the participant as a paid worker and may not receive compensation through participant-directed service funds. This ensures separation of employer authority and service provision responsibilities.

The appointment of a representative is documented in the Person-Centered Care Plan (PCCP) and may occur during the initial planning process or at any point during waiver participation. The Case Manager and Personal Choices Counselor review and approve the selection of a representative to ensure that no conflict of interest exists and that the representative is able to perform required duties.

The state ensures that representatives act in the best interest of the participant through the following safeguards:

Review and approval of the representative selection to ensure appropriateness and absence of conflict of interest

Documentation that the representative will carry out responsibilities in accordance with the participant's preferences, needs, and goals

Ongoing monitoring by the Case Manager to ensure services are delivered as authorized and that the participant's health and welfare are maintained

Participant access to change or revoke the representative at any time

These safeguards ensure that participant direction through a representative supports participant autonomy while protecting health, welfare, and service integrity.

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/Attendant Services	☒	☒

Appendix E: Participant Direction of Services

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:

Pursuant to the 1915j:

The FMSA will enroll with ADSS as a provider. The FMSA will not provide any direct services. The participant's budget is calculated by converting the eligible services in the waiver service plan to dollar amounts. The number of hours or units authorized for each service is multiplied by the current hourly or unit cost of the service. From this amount, 15% is allocated directly for administration expenses. This includes counseling and FMSA services. The 15% is usually less than the administrative costs that goes to a provider agency under the traditional program.

In most instances, the Targeted Case Manager performs the initial service plan assessment and then once approved for the waiver program, the Personal Choices counselor will set a date to meet with the individual to start enrollment into the Personal Choices Program. In some instances, the process occurs simultaneously. It is dependent upon the wishes of the individual.

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

Pursuant to the 1915j:

Alabama utilizes a Fiscal Employer Agent as our vendor for the Personal Choices Program. The vendor is selected through a Request For Proposal (RFP) procurement method. This procurement is for one vendor.

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

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:

Pursuant to the 1915j:

Alabama utilizes a Fiscal Employer Agent as the vendor for the Personal Choices Program. The vendor is selected through a Request For Proposal (RFP) procurement method. This procurement is for one vendor.

The FMSA activities will include bookkeeping services for the participant. The FMSA 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.

The Alabama Department of Senior Services (ADSS) is the enrolled Medicaid provider at this time. ADSS has a contract with the FMSA and pays them the administrative rate for their services.

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.

Pursuant to the 1915j:

ADSS 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 of discovery. Remediation of the problem will be expected within 48 hours of the FMSA being notified by ADSS.

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 TA Waiver Case Manager will play a significant role in the overall development of the participant's Person-Centered Care Plan (PCCP). The TA Waiver Case Manager will continue to assess supports and needs as well as health and safety risks as required by TA Waiver protocols. The TA Waiver Case Manager will perform re-assessment of the participant's level of care needs at least annually in order to resolve any identified health and safety issues.

Pursuant to the 1915j:

Information and assistance in support of participant direction are furnished through Medicaid administrative activities and case management functions, as applicable. Information and assistance are provided through distinct roles, including case management, the Personal Choices Counselor, and the Financial Management Services Agency (FMSA), each within their defined scope of responsibility. 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 ADSS 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 participant's 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
Pest Control Service	☐
Personal	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Care/Attendant Services	
Private Duty Nursing	☐
Medical Supplies	☐
Specialized Medical Equipment	☐

- ☒ **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:

Pursuant to the 1915j:

The ADSS Counselor will provide information to the waiver participant to support their efforts to direct their own individual services. This will occur during the initial assessment process, during reviews and updates to the Person-Centered Care Plan (PCCP). If the individual elects to direct their own services, they will be referred to the FMSA to provide employer related services. These include:

- Assisting participants with enrollment into the Personal Choices Program and completion of required documentation;
- Providing information to assist in employment of workers;
- Managing, on a monthly basis, all invoices for personal care services authorized in the participants' PCCP;
- 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 ADSS;
- Alabama Medicaid Agency and the operating agency conduct periodic administrative and operational reviews of FMSA performance, including review of reports, financial transactions, and compliance with contractual requirements;
- Alabama Medicaid and ADSS will monitor the FMSA, on a monthly basis during the first six months of operations and every six months thereafter.

Individuals enrolled in the Personal Choices option have supports through a variety of means. They have the traditional case manager as a source as well as the Personal Choices Counselor. The TA Case Manager provides general information about the Personal Choices program through case management activities. The individual is provided assistance supports for enrolling, developing the spending plan and other associated activities of self-direction through the Personal Choices Counselor. Assistance regarding FMS activities such as payroll questions, IRS requirements, budget balances, etc. are provided through the FMS vendor.

Assistance is reimbursable as an activity of Case Management services through the TA Waiver and is reimbursed on a fee for service basis. Counselor services are reimbursed through the Personal Choices Program as part of the administrative portion of the budget. The participant's budget is calculated by converting the eligible services in the waiver PCCP to dollar amounts. The number of hours or units authorized for each service is multiplied by the current hourly or unit cost of the service. From this amount, 15% is allocated directly for administration expenses. This includes counseling and FMSA services.

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 participant may elect to voluntarily discontinue participation in the Personal Choices Program at any time. The participant must notify the Personal Choices Counselor of the decision to disenroll, which may be communicated by phone, mail, or electronic means. The Counselor documents the participant's request and initiates the disenrollment process within ten (10) business days of notification.

Upon notification, the Case Manager and Personal Choices Counselor coordinate to ensure a safe and orderly transition to traditional provider-managed services. A face-to-face or direct contact is conducted to:

Assess the participant's current health, safety, and welfare status

Identify and address any concerns that may have contributed to the decision to discontinue participant direction

Confirm the participant's decision to disenroll

Explain the process and timeline for transitioning to traditional service delivery

Assist the participant in selecting qualified providers for continued services

Facilitate the transition of the participant-directed budget to authorized waiver services included in the Person-Centered Care Plan (PCCP)

The transition to traditional waiver services is initiated promptly and is typically completed within 15 to 45 days. Participant-directed services continue without interruption until traditional services are fully implemented to ensure continuity of care and protection of the participant's health and welfare.

The Alabama Medicaid Agency and the operating agency oversee the transition process to ensure that services are authorized and delivered in accordance with the PCCP and that no gaps in service delivery occur.

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.

The State may involuntarily terminate a participant’s use of participant direction and transition the participant to traditional provider-managed services when it is determined that continued participation in the Personal Choices Program compromises the participant’s health, safety, or welfare, or when program requirements are not met.

The participant is provided with written notice of the involuntary termination, including the reason for the action and information regarding the right to request an informal review and a Medicaid Fair Hearing.

Participants may be involuntarily disenrolled from participant direction for the following reasons:

Health, safety, and welfare concerns: When the participant’s health, safety, or well-being is compromised or threatened by continued participation in participant direction

Inability to self-direct: When the participant is no longer able to manage employer or budget authority and no qualified representative is available

Misuse of participant-directed funds: When funds are not used in accordance with the approved Person-Centered Care Plan (PCCP), including failure to pay workers or required employment-related taxes

Under-utilization of the participant-directed budget: When failure to utilize authorized services places the participant’s health or welfare at risk

Failure to comply with program requirements: Including failure to provide required documentation or comply with program policies after written notice and opportunity to correct

Prior to involuntary termination, the participant is provided written notice and an opportunity to resolve identified issues when appropriate. If the issues are not resolved, the State proceeds with disenrollment.

Participants have the right to request an informal review within 30 days of the notice of involuntary termination. The Alabama Medicaid Agency and the operating agency complete the informal review and issue a decision within 30 days of receipt of the request.

If the participant is dissatisfied with the outcome of the informal review, the participant may request a Medicaid Fair Hearing in accordance with 42 CFR Part 431, Subpart E.

Traditional waiver services are arranged and authorized promptly upon initiation of the involuntary termination process. Participant-directed services continue without interruption until traditional services are in place to ensure continuity of care and protection of the participant’s health and welfare.

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		20
Year 2		20
Year 3		20
Year 4		20
Year 5		20

Appendix E: Participant Direction of Services

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 required background investigations is included as part of the administrative services provided by the Financial Management Services Agency (FMSA) for participant-directed services.

- ☐ **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:

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.

Pursuant to the 1915j:

The State assures that the methodology used to establish budgets will meet the following criteria:

- A. Each participant's budget will be established based on the current hours of traditional personal care hours received each week. A portion of the participant-directed budget is allocated for Financial Management Services (FMS) administrative costs, in accordance with the approved methodology for administration of the participant-directed personal/ attendant care services included in the Person-Centered Care Plan (PCCP). The primary choice for the participant will be the decision regarding who will provide their personal care services.
- B. The number of hours that a participant will receive is based on the individual assessment of need and will remain unchanged, unless the individual's need changes. The participant-directed budget is derived directly from the personal care hours authorized in the person-centered care plan (PCCP). 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 change in need identified during the home visit or by other means based on the assessment of need will be indicated on the participant's PCCP.
- D. Policy and procedures will describe the formula used to establish each participant's budget which will be applied consistently for each participant who chooses the participant-directed option.
- E. Information about the budget methodology will be made available to the public through, ADSS website, as well as published materials, formal and informal oral presentations.

Personal Choices participants are informed about the complaint and appeal process during the enrollment process. The Financial Counselor and TA Waiver Case Manager and Counselor provide participants with documents that explains how and when to file an appeal.

Each individual develops a spending plan based on the dollar amount of their participant-directed budget. The individual is provided a Participant Handbook that outlines in detail, the process of developing a spending plan. The handbook provides examples and guidance on the formulation of the spending plan. The Personal Choices Counselor meets with the individual and explains the process further along with the requirements of the program and addresses any questions they may have about the process. The individual determines who their employees will be, what services they need, whether there are goods and services they wish to purchase, whether they want to establish a savings account for specific items needed or whether they elect to allocate budgeted funds for allowable goods and services in accordance with the approved spending plan. Tools and guidance are provided to assist participants in developing and managing their spending plan.

The purchase of goods and services are authorized under the 1915(j) option in the state plan. Participants may allocate funds for allowable goods and services in accordance with 1915(j) authorities, when such purchases increase independence or substitute for human assistance, and are included in the approved spending plan.

Authority used:

- § 441.482 Permissible purchases. (a) Participants, or their representatives, if applicable, may, at the State's option, use their service budgets to pay for items that increase a participant's independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.
- § 441.470 Service budget elements. (d) The procedure(s) that governs how a person, at the election of the State, may reserve funds to purchase items that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance, including additional goods, supports, services or supplies.

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 participant-directed budget during the person-centered planning process. The budget is developed based on the authorized services and supports identified in the Person-Centered Care Plan (PCCP) and is communicated to the participant prior to the initiation of participant-directed services.

Participants are informed of both the preliminary budget amount during plan development and the final approved budget amount upon completion of the PCCP and enrollment into the Personal Choices Program. The Personal Choices Counselor provides education and guidance to ensure the participant understands the budget amount, how it was determined, and how it may be used in accordance with program requirements.

Participants may request adjustments to the participant-directed budget at any time based on changes in needs or circumstances. Requests for budget adjustments are initiated through the Case Manager and are evaluated through reassessment and updates to the PCCP. Budget adjustments are approved when supported by documented changes in the participant's assessed needs.

Participants are informed of their right to appeal any reduction, denial, or change in services or budget amounts in accordance with Medicaid Fair Hearing requirements. Written notice is provided when applicable.

Information regarding the budget methodology and participant rights is made available through Alabama Medicaid Agency and operating agency resources, as well as through participant education materials.

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 State has established safeguards to ensure the appropriate use of participant-directed budgets and to prevent premature depletion or underutilization of funds.

The Financial Management Services Agency (FMSA) is responsible for ongoing monitoring of participant expenditures. The FMSA reviews spending patterns on a regular basis to ensure that expenditures align with the approved spending plan and that sufficient funds remain available to meet the participant's assessed needs. The FMSA identifies potential over-expenditures, underutilization, or irregular spending patterns and reports these findings to the operating agency for follow-up.

The Case Manager monitors service delivery and the participant's needs through ongoing contact and reassessment. If changes in the participant's condition or needs are identified, the Person-Centered Care Plan (PCCP) is updated accordingly, and the participant-directed budget may be adjusted to reflect those changes.

The Personal Choices Counselor provides training, education, and technical assistance to participants and their representatives on budget management, allowable expenditures, and program requirements. This support helps participants effectively manage their budgets and avoid both over-expenditure and underutilization.

When issues are identified, the State and operating agency implement corrective actions, which may include additional counseling, increased monitoring, or modification of the spending plan to ensure the participant's health and welfare needs are met.

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.

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) 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. The state provides notice of action as required in 42 CFR § 431.210.

The Alabama Medicaid Agency provides an opportunity for a fair hearing in accordance with 42 CFR Part 431, Subpart E, including timely and adequate notice and the opportunity to appeal adverse actions taken by the Alabama Medicaid Agency or its designee that affect a participant's eligibility for, or receipt of, waiver services. A hearing officer designated by the Commissioner of the Alabama Medicaid Agency conducts fair hearings. If the individual or their legal representative is dissatisfied with the hearing decision, they may appeal to the Circuit Court.

TA Waiver participants are provided with information regarding their right to a fair hearing upon enrollment, annually at redetermination, and at the time of any adverse action. As part of the initial assessment and annual redetermination process, participants sign documentation acknowledging that they have been informed of their right to choose between institutional care and home and community-based services. Participants are also provided a list of qualified providers and are afforded freedom of choice among those providers.

The ADSS Targeted Case Manager explains the procedures when services are reduced, suspended, denied, or terminated and issues a written notice of action at least 10 days in advance of the effective date of the action, consistent with 42 CFR § 431.210. The notice includes: (1) a description of the action the agency intends to take; (2) the reasons for the intended action; (3) information about the participant's right to request a fair hearing; and (4) an explanation of the circumstances under which services will continue if a hearing is requested.

Targeted Case Managers assist participants, upon request, in completing and submitting fair hearing requests. Information regarding appeal rights and procedures is also included in the person-centered care plan, a copy of which is provided to the participant.

Participants or their legally authorized representative may request a fair hearing within 30 days of the date of the notice of action. If a hearing request is received within 10 days of the effective date of the action, services will continue pending the outcome of the hearing, in accordance with 42 CFR § 431.230.

If an optional informal conference is held and the participant remains dissatisfied, the participant or their representative may request a fair hearing within 30 days of the notice of action. Hearing requests must be submitted in writing and must include a valid mailing address. If the request is made by someone other than the participant, the individual must indicate that they are authorized to act on the participant's behalf.

If the participant chooses to withdraw the hearing request prior to the hearing, the participant or their representative must notify the Alabama Medicaid Agency in writing.

Copies of all notices of action and hearing-related documentation are maintained in the participant's case record and in Alabama Medicaid administrative files.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

☐ **No. This Appendix does not apply**

☒ **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency operates an additional dispute resolution process known as the Informal Conference. This process allows participants to dispute decisions related to eligibility, choice of provider or service, or the denial, reduction, suspension, or termination of waiver services. The Informal Conference is voluntary and does not replace, delay, or limit the participant's right to request a Medicaid Fair Hearing at any time.

Participants are notified of the Informal Conference option through the written notice of action and through materials provided at enrollment, annually, and at the time of any adverse action. The ADSS Targeted Case Manager issues a 10-day advance notice prior to the reduction, suspension, denial, or termination of services.

To initiate an Informal Conference, the participant, applicant, or their legal representative must submit a written request to the Alabama Medicaid Agency Program Manager within 30 days from the date of the notice of action. The Informal Conference may address disputes involving eligibility, service amount, service type, provider choice, or termination of services.

If the participant is not satisfied with the outcome of the Informal Conference, a request for a fair hearing must be submitted within 30 days of the notice of action. If a hearing request is received within 10 days of the effective date of termination, services may continue pending the outcome of the hearing, in accordance with 42 CFR § 431.230. Participants are informed of this right in the notice of action.

If services are continued pending the outcome of the hearing and the hearing decision upholds the termination, the Alabama Medicaid Agency may recover the cost of services furnished during the continuation period, consistent with federal requirements.

Copies of Informal Conference requests, decisions, and related documentation are maintained in the participant's case record and in Alabama Medicaid administrative records. Use of the Informal Conference process is not required prior to requesting a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Alabama Medicaid Agency operates a grievance and complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under the waiver.

The Alabama Medicaid Agency is responsible for the operation of the grievance and complaint system. Alabama Medicaid receives, tracks, reviews, and resolves complaints submitted by participants, their representatives, ADSS Targeted Case Managers, or provider agencies. Alabama Medicaid ensures that participants are informed of their rights and the procedures for filing complaints. Complaints may be reported directly to Alabama Medicaid. A tracking log is maintained to document each complaint and its resolution. Alabama Medicaid retains final responsibility for complaint resolution and documentation.

- **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).

(a) Types of Grievances/Complaints

Participants may file grievances or complaints related to any aspect of the provision of waiver services. This includes, but is not limited to, concerns regarding service delivery, timeliness of services, provider performance, participant rights, health and safety, quality of care, communication, and the implementation of the person-centered care plan. Participants may also file complaints related to unmet needs, changes in services, or dissatisfaction with waiver staff, providers, or processes.

(b) Process and Timelines for Addressing Grievances/Complaints

The Alabama Medicaid Agency receives grievances and complaints submitted by participants, their representatives, ADSS Targeted Case Managers, or provider agencies. Complaints may be reported directly to Alabama Medicaid.

Upon receipt, complaints are logged and reviewed. If the complaint involves abuse, neglect, or exploitation, it is reported immediately to the Alabama Department of Human Resources, Adult Protective Services, and an investigation is initiated without delay.

For all other complaints, appropriate parties are notified within 24 hours of receipt. Investigations are initiated as soon as possible, but no later than seven working days. Resolution of the complaint is expected within 14 working days, unless additional time is necessary due to the complexity of the issue, in which case the participant is informed of the status.

If a participant's health or safety is at risk, immediate action is taken to ensure the participant's protection. The Alabama Medicaid Agency, in coordination with the ADSS Targeted Case Manager and Alabama Medicaid Nurse Reviewer, ensures that appropriate follow-up occurs and that risks are mitigated.

All complaints and actions taken are documented in a tracking log maintained by the Alabama Medicaid Agency.

(c) Mechanisms Used to Resolve Grievances/Complaints

The Alabama Medicaid Agency oversees the investigation and resolution of grievances and complaints. Resolution mechanisms may include, but are not limited to, coordination with providers and case managers, corrective actions by provider agencies, additional monitoring, reassessment of participant needs, and modification of the person-centered care plan.

The Alabama Medicaid TA Waiver Coordinator reviews complaint data on a quarterly basis to ensure that all issues have been resolved and to identify trends or patterns that may require system-level improvements. Follow-up with the participant or representative may be conducted to confirm that the issue has been resolved to their satisfaction.

Participants are informed of the outcome of the complaint and their right to request a Medicaid Fair Hearing if the issue involves an adverse action. Use of the grievance/complaint system is not a prerequisite to requesting a Fair Hearing.

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 or 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.

Reports submitted through the Gateway to Community Living Portal are immediately accessible to the Alabama Department of Senior Services (ADSS) for review, investigation, and follow-up action. ADSS is responsible for monitoring reported incidents, initiating required response activities, and ensuring appropriate corrective actions are taken.

The Alabama Medicaid Agency is informed of critical incidents through electronic access to incident reports and through notifications and summaries provided by ADSS. Critical incidents that involve serious injury, death, abuse, neglect, or exploitation, or that present systemic concerns are communicated to Alabama Medicaid in accordance with established reporting protocols.

ADSS and the Alabama Medicaid Agency coordinate the review of reported incidents to determine appropriate actions, identify trends or patterns, and ensure participant health and safety protections are maintained. While ADSS is responsible for monitoring reported incidents, initiating response activities, and ensuring corrective actions are implemented, the Alabama Medicaid Agency is responsible for the final review and closure of critical incidents reported through the Gateway to Community Living Portal. Final determinations and closure decisions are documented by Alabama Medicaid in accordance with established incident management protocols.

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.

The Alabama Medicaid Agency is the entity responsible for the review and response to all reported critical events and incidents. Reports of critical incidents are submitted through the Gateway to Community Living Portal.

The Alabama Department of Senior Services (ADSS), through its contracted Targeted Case Management (TCM) functions, receives notifications of critical incidents and is responsible for entering incident reports into the Gateway system and ensuring timely reporting in accordance with established requirements.

Upon receipt of a reported incident through the Gateway system, the Alabama Medicaid Agency conducts an initial review to determine the severity of the incident and whether immediate action is required to protect the participant's health and welfare. If the incident indicates an immediate risk, appropriate interventions are initiated within 24 hours.

The Alabama Medicaid Agency is responsible for evaluating all reported incidents, including review of submitted documentation, requesting additional information as needed, and coordinating investigations. All allegations of abuse, neglect, or exploitation are referred to the Alabama Department of Human Resources and law enforcement, as required, and are investigated in accordance with applicable state laws.

ADSS Targeted Case Managers support the incident response process by monitoring the participant's status, ensuring appropriate services and supports are in place, and following up on identified issues. The Case Manager also communicates outcomes to the participant and/or their representative, as appropriate.

For incidents requiring additional follow-up, the Alabama Medicaid Agency assigns corrective actions and establishes timeframes for completion based on the nature and severity of the incident. Investigations and follow-up activities are generally completed within 30 days of the initial report, unless circumstances require additional time. In such cases, documentation is maintained to support the extended timeframe.

The Alabama Medicaid Agency reviews all incidents for final determination and closure. Incident data is also analyzed to identify trends and patterns, ensuring that systemic issues are addressed and participant health and welfare protections are maintained.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

Alabama Medicaid Agency, as the operating agency for the Technology Assisted (TA) Waiver, is responsible for oversight of the reporting of and response to critical incidents and events affecting waiver participants.

Oversight is conducted through ongoing review of incident data maintained in the Gateway to Community Living Portal, where all reported incidents are tracked through resolution. Alabama Medicaid has final authority for review and closure of all reported incidents.

Oversight activities include review and analysis of multiple data sources, including incident reports, complaint logs, participant medical records, direct service provider personnel records, and findings from onsite home and provider visits conducted as needed. Additional input is obtained through participant and family interviews and annual participant satisfaction surveys.

The Alabama Medicaid QA conducts routine monitoring of reported incidents to identify patterns, trends, and potential systemic issues. This includes evaluating the causes of incidents, assessing whether incidents could have been prevented, and determining the need for corrective actions such as additional provider training, policy clarification, or other system improvements. Findings are shared with ADSS, as the Targeted Case Management contractor, and with providers as appropriate.

Oversight is conducted on an ongoing basis, with incident data reviewed regularly and formal trend analysis performed at least quarterly. Alabama Medicaid also convenes regular Quality Assurance meetings with ADSS and other involved entities to review incident trends, discuss identified issues, and ensure appropriate corrective actions are implemented.

Through these activities, Alabama Medicaid ensures that critical incidents are appropriately reported, investigated, and resolved, and that information derived from incident management is used to improve service delivery systems and protect the health and welfare of waiver participants.

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 State prohibits the use of restraints and seclusion in the delivery of waiver services. Any unauthorized use of restraints is considered a critical incident and must be reported in accordance with the State's incident management requirements.

The Alabama Department of Senior Services (ADSS), through its Targeted Case Management functions, is responsible for monitoring for the unauthorized use of restraints during routine contacts with participants, including monthly face-to-face visits. Case Managers assess the participant's environment, service delivery, and overall health and welfare, and are required to report any suspected use of restraints through the Gateway to Community Living Portal.

The Alabama Medicaid Agency, as the operating agency for the waiver, provides oversight of restraint prohibition through review of reported incidents, complaint and grievance processes, participant satisfaction surveys, and onsite monitoring activities conducted as needed. All reports of suspected restraint use are reviewed and addressed through the State's incident management system.

Oversight is conducted on an ongoing basis, with monitoring occurring through regular case management activities and additional review through quality assurance processes. Any identified use of restraints is subject to investigation, corrective action, and follow-up to ensure participant health and welfare are protected.

- **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State prohibits the use of restrictive interventions in the delivery of waiver services. Any unauthorized use of a restrictive intervention is considered a critical incident and must be reported in accordance with the State's incident management requirements.

The Alabama Department of Senior Services (ADSS), through its Targeted Case Management functions, is responsible for monitoring for the unauthorized use of restrictive interventions during routine participant contacts, including monthly face-to-face visits. Case Managers review participant records, assess service delivery, and obtain participant and family feedback to identify any restrictions on participant rights, access, or movement that are not authorized.

The Alabama Medicaid Agency, as the operating agency for the waiver, provides oversight through review of reported incidents, complaint and grievance processes, participant satisfaction surveys, and onsite monitoring activities conducted as needed. All suspected or identified restrictive interventions are addressed through the State's incident management system.

Oversight is conducted on an ongoing basis through routine case management activities and quality assurance processes. Any identified use of restrictive interventions is subject to investigation, corrective action, and follow-up to ensure participant health and welfare are protected.

- **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 prohibits the use of seclusion in the delivery of waiver services. Any unauthorized use of seclusion is considered a critical incident and must be reported in accordance with the State's incident management requirements.

The Alabama Department of Senior Services (ADSS), through its Targeted Case Management functions, is responsible for monitoring for the unauthorized use of seclusion during routine participant contacts, including monthly face-to-face visits. Case Managers assess the participant's environment, service delivery, and overall health and welfare and are required to report any suspected use of seclusion through the Gateway to Community Living Portal.

All waiver providers and case managers are required to report any suspected or alleged use of seclusion. Incidents involving seclusion are also referred to the Alabama Department of Human Resources and law enforcement, as appropriate, in accordance with the Alabama Adult Protective Services Act.

The Alabama Medicaid Agency, as the operating agency for the waiver, provides oversight through review of reported incidents, complaint and grievance processes, participant satisfaction surveys, and onsite monitoring activities conducted as needed. All reports of suspected seclusion are reviewed and addressed through the State's incident management system.

Oversight is conducted on an ongoing basis through routine case management activities and quality assurance processes. Any identified use of seclusion is subject to investigation, corrective action, and follow-up to ensure participant health and welfare are protected.

- **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- **No. This Appendix is not applicable** (do not complete the remaining items)
- **Yes. This Appendix applies** (complete the remaining items)

- **Medication Management and Follow-Up**

Do not complete this section

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards**Appendix G-3: Medication Management and Administration (2 of 2)****c. Medication Administration by Waiver Providers****Answers provided in G-3-a indicate you do not need to complete this section**

- i. Provider Administration of Medications.** *Select one:*

- ☒ **Not applicable.** *(do not complete the remaining items)*
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
 - **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- **Medication Error Reporting.** *Select one of the following:*
 - ☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

- 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:

and % 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 [# of providers required to complete annual training]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record reviews, on-site (Certification: Training verification forms)

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

Data Aggregation and Analysis:

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

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 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):

Record reviews, on-site

If 'Other' is selected, specify:

Gateway to Community Living Portal

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of abuse, neglect, exploitation, or unexplained death incidents reviewed/investigated within the required timeframe. **NUMERATOR** [Total number of abuse, neglect and exploitation or unexplained death incidents reviewed/investigated within the required timeframe] / **DENOMINATOR** [Number of abuse, neglect and exploitation or unexplained death incidents]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Gateway to Community Living Portal

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

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

	Ongoing	Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of case managers]

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

If 'Other' is selected, specify:

Record reviews, on-site (Certification: Training verification forms)

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of closed cases of abuse/neglect/exploitation for which Alabama Medicaid 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):**Other**

If 'Other' is selected, specify:

Gateway to Community Living Portal

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Number and percent of critical incident trends 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):

Other

If 'Other' is selected, specify:

Gateway to Community Living Portal

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

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 critical incidents that have been resolved by Alabama Medicaid within 60 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by Alabama Medicaid within 60 days of the date of the critical incident report date] / DENOMINATOR [Number of reported critical incidents]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Gateway to Community Living Portal

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

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

Data Aggregation and Analysis:

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

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

Number and percent of participant records reviewed that do not identify previously unreported incidents of unauthorized restrictive interventions or seclusion.

Percentage = NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):

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% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

- d. **Sub-assurance: 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	☐ Annually	☐ Stratified

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of people who responded that their overall health was Good, Very Good, or Excellent. Percentage = NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent] / DENOMINATOR [Number of surveys containing responses regarding health reviewed]

Data Source (Select one):

Other

If 'Other' is selected, specify:

NCI Survey

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 9.8
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☒ Other Specify: Sample size deemed appropriate by NCI.
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of participants reviewed who had an ambulatory or preventive care visit during the year. Percentage = NUMERATOR [Number of participants who had an ambulatory or preventive care visit during the year] / DENOMINATOR [Number of participants]

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

If 'Other' is selected, specify:

MMIS

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

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

Data Aggregation and Analysis:

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

- 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 Targeted Case Manager will monitor participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager will also report any events of this nature to the AMA TA Waiver Coordinator in the approved format within the required guidelines. The Targeted Case Manager will track reports to resolution for documentation and will report the resolution to the AMA TA Waiver Coordinator.

AMA TA Waiver Coordinator will ensure that all reported instances of abuse or neglect are investigated on an ongoing basis and will track the number of substantiated allegations monthly.

AMA TA Waiver Coordinator will ensure that recommendations included in investigative reports are implemented as required on an ongoing basis. AMA TA Waiver Coordinator will review and analyze critical incident data at the individual, provider and state levels as needed, but on at least a quarterly basis. All findings related to the participant safeguards will be documented and communicated to the ADSS Targeted Case Manager and service provider as appropriate for corrective

action.

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.

Complaints that AMA receives are documented on a log. The DSP is required to inform the participant/responsible party of their right to register a complaint with the ADSS Targeted Case Manager and the AMA. AMA TA Waiver Coordinator will conduct reviews of complaints received by the DSP during audits of the providers.

The TA Waiver Coordinator reviews case records and identifies problems that could be indicative of a systemic problem. If multiple participants are experiencing the same acute condition or critical incident, ADSS and the targeted case manager would be notified to investigate further and follow up with their findings.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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, as the Operating Agency for the Technology Assisted (TA) Waiver, maintains a continuous quality improvement strategy to ensure participant health and welfare, monitor compliance with waiver requirements, and promote system performance.

Data Sources

Multiple data sources are utilized to assess waiver performance, including:

- * Consumer surveys
- * Case management and clinical records
- * Complaint and grievance logs
- * Home visit and monitoring documentation
- * Targeted and focused reviews
- * Alabama Medicaid Quality Assurance (QA) performance measurement system data
- * Claims and service authorization data
- * Provider records and documentation

Monitoring Methodology

Alabama Medicaid employs a comprehensive monitoring approach that includes both 100% review activities and statistically valid sampling methodologies.

All annual redeterminations (100%) are reviewed by the designated nurse reviewer and subsequently undergo a secondary 100% quality assurance review by the Alabama Medicaid QA Division nurse to ensure compliance with medical necessity, service authorization, and waiver requirements.

In addition, QA staff conduct home visits for 100% of TA Waiver participants annually to assess service delivery, participant health and welfare, satisfaction, and adherence to the Person-Centered Care Plan (PCCP).

For performance measures not subject to 100% review, Alabama Medicaid utilizes a representative sample methodology with a 95% confidence level and a margin of error of +/- 5%, consistent with approaches across state waiver programs.

QA data are entered into the QA performance measurement system and reviewed on a quarterly basis to evaluate compliance with established performance measures, identify trends, and detect potential areas of non-compliance.

In addition to routine monitoring, Alabama Medicaid conducts targeted and focused reviews, including review of complaints, grievances, critical incidents, and outlier cases, to ensure timely identification and resolution of issues.

Given the medical complexity of the TA Waiver population, this multi-tiered monitoring approach ensures comprehensive oversight of all participants while supporting early identification of risks.

Performance Measures

Alabama Medicaid monitors performance across the following domains:

1. Participant Experience and Outcomes

- * Percentage of participants reporting satisfaction with waiver services and that their needs are met
- * Percentage of participants reporting they feel safe and secure in their home and community
- * Percentage of participants reporting access to needed services and supports
- * Percentage of participants demonstrating knowledge of rights and responsibilities

2. Service Planning and Delivery

- * Percentage of records indicating services are planned and implemented in accordance with the participant's assessed needs, preferences, and PCCP

3. Provider Qualifications and Oversight

* Percentage of providers meeting qualification requirements, including verification of credentials and completion of required training

* Evidence that provider monitoring and oversight activities are conducted in accordance with established policies

Performance Standards and Remediation

A performance standard of 86% compliance is established for all measures unless otherwise specified.

When non-compliance is identified:

* Individual issues are addressed within 30 calendar days

* Corrective actions may include provider education, retraining, plan revision, recoupment, or referral to Program Integrity, as appropriate

* Follow-up monitoring is conducted to ensure that corrective actions are implemented and effective

System Improvement Activities

Alabama Medicaid conducts ongoing system improvement activities based on the analysis of quality data.

Quality data are reviewed on a quarterly basis by Alabama Medicaid and QA staff to evaluate waiver performance, identify trends, and detect areas of non-compliance. This review includes analysis of participant outcomes, provider performance, incident and complaint data, and service delivery patterns.

Based on these reviews, Alabama Medicaid implements corrective and system-level improvement strategies, which may include:

* Policy or procedural revisions

* Targeted provider training and technical assistance

* Enhanced monitoring or focused reviews

* Updates to guidance, tools, or oversight processes

Follow-up monitoring is conducted to ensure that corrective actions are implemented and effective in resolving identified issues.

An annual comprehensive review of quality data is conducted to evaluate the overall effectiveness of the waiver program and to guide long-term system improvement planning.

Alabama Medicaid collaborates across internal divisions, including QA and Program Integrity, to implement corrective strategies and monitor the effectiveness of system improvements.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Quality Improvement Committee	☒ Annually
☐ Other Specify:	☐ Other Specify:

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Alabama Medicaid is responsible for collecting and analyzing data regarding the quality of services provided through the Technology Assisted (TA) Waiver. Data collected addresses performance measures associated with each of the waiver assurances and is analyzed to determine compliance and identify areas requiring system improvement.

Data Collection and Monitoring

Data is collected from multiple sources, including:

- * Critical incident reports entered into the Gateway system and reviewed per occurrence by Alabama Medicaid Quality Assurance (QA) staff
- * Participant satisfaction surveys (Expert Scan reports), reviewed quarterly for overall satisfaction, complaints, and resolution of identified issues
- * Participant Plans of Care, reviewed on an ongoing basis for new participants and annually for established participants to ensure accuracy, timeliness, and alignment with assessed needs and preferences
- * Provider enrollment and licensure reports to verify qualified provider status
- * Billing and service authorization data (Data Sheet Reports) reviewed during redeterminations and on-site audits
- * Monitoring of Alabama Department of Senior Services (ADSS) operations and performance through ongoing oversight and annual on-site audits

QA staff utilize the Gateway system and other reporting tools to track trends, frequency, outcomes, and resolution of critical incidents and other performance indicators.

Roles and Responsibilities

Alabama Medicaid, as the Operating Agency, is responsible for oversight of waiver performance, identification of system design changes, and implementation of corrective strategies. The TA Waiver Coordinator is responsible for reviewing data, conducting audits, and coordinating corrective actions. The QA Division is responsible for data collection, validation, and analysis, including review of critical incidents, participant records, and performance reports. ADSS and targeted case managers are responsible for implementation of services, reporting of critical incidents, and participation in quality improvement activities.

Monitoring and Analysis of System Design Changes

Alabama Medicaid monitors the effectiveness of system design changes through ongoing data analysis and quarterly review of performance indicators. The TA Waiver Coordinator, Long Term Care Division, QA staff, ADSS, and targeted case managers meet on a quarterly basis to review data, assess trends, and evaluate the impact of implemented changes.

System design changes, including policy revisions, process improvements, or system updates (e.g., enhancements to the Gateway system), are evaluated by comparing performance data over time to determine whether compliance and participant outcomes improve.

If performance does not meet the established 86% compliance threshold, additional corrective actions and targeted monitoring are implemented.

Corrective Action and Follow-Up

During audits, if deficient practices are identified, the TA Waiver Coordinator compiles supporting documentation and notifies the provider. Providers are required to submit a corrective action plan within 15 days of notification. Alabama Medicaid reviews and approves corrective action plans and verifies implementation during subsequent monitoring activities, including follow-up audits.

Critical incidents and adverse survey responses are tracked through resolution, and targeted follow-up surveys are conducted to ensure participant satisfaction with corrective actions.

System Improvement and Communication

Findings from data analysis are used to identify and prioritize system improvements based on the severity and scope of identified issues. Strategies may include provider education, training, corrective action plans, and system or process modifications.

Alabama Medicaid communicates system changes to participants, families, providers, and stakeholders through multiple channels, including case manager visits, written notifications, the Alabama Medicaid website, and other public communication methods.

The effectiveness of system improvements is assessed through ongoing monitoring of performance data and trends. Revisions to the Quality Improvement Strategy are made as needed to ensure continued compliance and improvement in waiver performance.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Alabama Medicaid periodically evaluates the effectiveness of the Quality Improvement Strategy (QIS) through ongoing review of performance data and system outcomes.

The Alabama Medicaid TA Waiver Coordinator, in coordination with Quality Assurance (QA) staff, reviews Participant Satisfaction Survey results, Quality Assurance Indicator reports, critical incident data, and other performance reports on a quarterly basis to assess overall waiver performance and identify trends.

An annual comprehensive review of all quality data is conducted to evaluate the effectiveness of the QIS in meeting established performance standards and ensuring participant health and welfare.

Remediation for non-compliance issues and complaints identified during data collection is initiated by requiring the responsible entity to submit a plan of correction within ****15 days**** of notification. If issues are not corrected, the severity of the deficiency is evaluated and additional actions are taken, which may include increased monitoring, technical assistance, or referral to Program Integrity.

Findings from quarterly and annual reviews are used to determine whether modifications to the Quality Improvement Strategy, performance measures, or monitoring processes are necessary to improve system performance and ensure continued compliance with waiver requirements.

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).

(a) Independent Audit Requirements

Providers of waiver services are subject to financial oversight to ensure that claims submitted for Medicaid reimbursement are accurate, allowable, and supported by documentation. Providers must maintain financial and service documentation sufficient to support all claims, including service authorizations, service delivery records, and financial records.

The State of Alabama Examiners of Public Accounts conducts independent financial audits in accordance with applicable state and federal requirements, including the Single Audit Act, as applicable.

(b) State Financial Audit Program (Methods, Scope, and Frequency)

Alabama Medicaid conducts a post-payment financial audit program designed to ensure that only reasonable, necessary, and allowable costs are reimbursed for waiver services.

Audit activities include review of provider records and supporting documentation, including but not limited to:

Provider contracts and cost allocation documentation;
General ledger accounts, cash disbursements, and receipts;
Payroll records, including time sheets;
Claims, billing records, and service documentation; and
Verification of revenues received from Medicaid.

A statistically valid sampling methodology is used to select claims and expenditures for review. All records must be capable of audit verification, and any costs that cannot be verified are subject to disallowance.

Financial oversight also includes retrospective reviews of provider billing, with a sample of claims selected for detailed review to ensure compliance with Medicaid requirements.

Alabama Medicaid utilizes an Electronic Visit Verification and Monitoring (EVVM) system for applicable in-home services to validate service delivery and support accurate billing. The EVVM system captures visit data, including time and location of service delivery, and supports real-time monitoring and verification of services.

(c) Entity Responsible for Conducting Financial Audit Program

Alabama Medicaid is responsible for administering the financial audit program and ensuring the integrity of payments for waiver services.

Gainwell Technologies serves as the Medicaid Management Information System (MMIS) contractor and performs pre-payment claims review to verify Medicaid eligibility and support accurate claims processing.

The Alabama Department of Examiners of Public Accounts conducts independent external audits of the Alabama Medicaid Agency, including waiver expenditures, in accordance with the Single Audit Act. The State submits an annual Schedule of Expenditures of Federal Awards (SEFA), which includes waiver expenditures under CFDA 93.778.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial

accountability of the waiver program.

i. Sub-Assurances:

- a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

Performance Measures

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

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

Performance Measure:

Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver document. Percentage = NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver] / DENOMINATOR [Number of claims paid]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Claims data (MMIS)

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participant records that show claims were coded correctly, and paid, only for services that were rendered. Percentage = NUMERATOR [Number of participant records reviewed that show claims were coded correctly, and paid, only for services that were rendered] / DENOMINATOR [Number of participant records reviewed]

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

If 'Other' is selected, specify:

Claims data (MMIS) Participant Record Reviews, On-site

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

Agency		
☐ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology]/DENOMINATOR [Number of rates reviewed]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Claims data (MMIS)

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

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

Data Aggregation and Analysis:

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

- 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 fiscal agent for AMA has edits in the system to ensure that the participant has Medicaid financial eligibility and TA Waiver eligibility before claims are paid.

To ensure timely payment to providers AMA is notified of any claims payment issues and will work with HPE to resolve them as quickly as possible.

AMA through internal claims queries can track payments and denials for each waiver participant, as well as the cost of 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.

If problems with claims are identified, the AMA TA Waiver Coordinator will notify the appropriate Agency staff to review the claim, and send the provider a letter to readjust the claim or the AMA will recoup the money.

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).

Alabama Medicaid is responsible for establishing provider payment rates for waiver services. Payments made by Medicaid to TA Waiver providers are on a fee-for-service basis and are based upon a number of factors:

1. Current pricing for similar services,
2. State-to-State comparisons,
3. Geographical comparisons,
Geographical comparisons within the state, and
Comparisons of different payers for similar services.

For each waiver service, a procedure code is used with a rate assigned to each code. The Medicaid Management Information System (MMIS) pays the claim based upon the State's pre-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index. A fee schedule for services is available on the Medicaid website. Public and/or participant feedback regarding rates is possible through satisfaction surveys, email, or a telephone call.

Keeping rates at a level consistent with similar providers in other programs allows the agency to ensure there are enough providers to provide services and allow for an individual's freedom of choice. There are rural areas of the state that are difficult to staff. The agency recruits providers diligently for these areas. The addition of Self-direction to this program will offer more opportunities in areas where the providers are limited.

Rates for Waiver services are established by Alabama 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. A provider may request a rate review at any time.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The MMIS pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

Rates 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.

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:

Providers of waiver services submit claims directly to the Alabama Medicaid Agency through the Medicaid Management Information System (MMIS), operated by Gainwell Technologies.

Claims are submitted electronically using approved procedure codes and units of service. The MMIS processes claims in accordance with established pricing methodologies, service authorizations, and Medicaid policy requirements.

Payments are made directly by the Alabama Medicaid Agency to enrolled providers. All providers must have an executed provider agreement with Alabama Medicaid and must be enrolled and authorized prior to submitting claims.

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 Alabama Medicaid Agency validates provider claims through the Medicaid Management Information System (MMIS), operated by Gainwell, to ensure that payment is made only for eligible participants, authorized services, and services that were rendered.

(a) Participant Eligibility

The MMIS verifies that the individual is eligible for Medicaid and enrolled in the waiver on the date of service. Claims are denied if eligibility criteria are not met.

(b) Service Authorization

Claims are validated against the participant's approved person-centered service plan to ensure that the service is authorized, within established service limits, and consistent with waiver requirements. Claims exceeding authorized units or outside approved services are denied or suspended for review.

(c) Verification of Service Delivery

For applicable services, the Alabama Medicaid Agency utilizes an Electronic Visit Verification and Monitoring (EVVM) system to confirm that services were delivered as billed, including verification of service date, time, and location. Claims are subject to edits to identify duplicate billing, overlapping services, and inconsistencies with service authorizations.

All claims are subject to automated system edits and pre-payment review to ensure required data elements are complete and accurate, including recipient identification, provider enrollment status, and valid procedure codes.

Claims that fail system edits are denied or returned to the provider for correction. Suspended claims are reviewed by Gainwell or Alabama Medicaid Agency staff, as appropriate.

Additional validation occurs through post-payment review and audit activities conducted by the Alabama Medicaid Agency, including comparison of claims to service documentation and provider records.

- 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:

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:

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

- ☐ **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

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.

ii. Organized Health Care Delivery System. Select one:

- ☒ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- *The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.*
- *The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.*

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- *This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☒ **Appropriation of State Tax Revenues to the State Medicaid Agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

- ☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ☐ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** Select one:

- ☒ No services under this waiver are furnished in residential settings other than the private residence of the individual.
- ☐ As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- ☒ **No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	41477.68	25934.00	67411.68	111751.00	13495.00	125246.00	57834.32
2	42773.56	26712.00	69485.56	115103.00	13900.00	129003.00	59517.44
3	44002.07	27514.00	71516.07	118557.00	14317.00	132874.00	61357.93
4	45321.63	28339.00	73660.63	122113.00	14746.00	136859.00	63198.37
5	46683.90	29189.00	75872.90	125777.00	15189.00	140966.00	65093.10

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	80		48
Year 2	80		49
Year 3	80		50

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 4	80		51
Year 5	80		52

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is estimated at 344.5 days per year, based on data reported in the CMS-372 annual report for waiver year 2023–2024 (lag year).

This estimate is supported by historical data from prior years, which show an average length of stay of 345.7 days in waiver year 2022–2023 and 318.7 days in waiver year 2021–2022.

The State anticipates that the average length of stay will remain stable over the waiver renewal period, as the waiver serves individuals with long-term, complex medical needs who require continuous support to remain safely in the community.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The Derivation Factor D represents the average per capita cost of waiver services and is calculated by dividing total waiver service expenditures by the total number of unduplicated participants served.

The estimates for Factor D are based on historical waiver service utilization and expenditure data obtained from the State's Medicaid Management Information System (MMIS) and reported in CMS-372 annual reports for waiver years 2022 through 2024. These data include the number of users, units of service per user, and average cost per unit.

Trends in utilization and expenditures were analyzed across these years to develop projected cost estimates. An annual growth factor of approximately 3.0 percent is applied, based on observed historical trends and consistent with expected increases in medical costs, service utilization, and provider reimbursement over the waiver renewal period.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Derivation Factor D' represents the average per capita cost of State Plan services utilized by waiver participants.

The estimates for Factor D' are based on historical State Plan claims data obtained from MMIS for waiver participants during waiver years 2022 through 2024. These data reflect the utilization and expenditures for State Plan services used by individuals residing in the community.

Trends in State Plan service utilization and expenditures were analyzed across these years to develop projected cost estimates. An annual growth factor of approximately 3.0 percent is applied, based on observed historical trends and consistent with expected increases in medical costs and service utilization over the waiver renewal period.

- 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:

The Derivation Factor G represents the estimated per capita cost of institutional services and is calculated using the average daily Nursing Facility rate multiplied by the average length of stay.

The estimates for Factor G are based on Nursing Facility reimbursement rates and historical utilization and expenditure data for comparable populations obtained from MMIS and reflected in CMS-372 reports for waiver years 2022 through 2024.

Trends in institutional service costs were analyzed across these years to develop projected cost estimates. An annual growth factor of approximately 3.0 percent is applied, based on observed historical trends and consistent with anticipated increases in institutional reimbursement rates and associated costs over the waiver renewal period.

- 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:

The Derivation Factor G' represents the average per capita cost of State Plan services for individuals receiving institutional care.

The estimates for Factor G' are based on historical State Plan claims data for individuals in institutional settings obtained from MMIS for waiver years 2022 through 2024.

Trends in utilization and expenditures were analyzed across these years to develop projected cost estimates. An annual growth factor of approximately 3.0 percent is applied, based on observed historical trends and consistent with expected increases in medical costs and service utilization over the waiver renewal period.

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	
Personal Care/Attendant Services	
Private Duty Nursing	
Medical Supplies	
Pest Control Service	
Specialized Medical Equipment	

Appendix J: Cost Neutrality Demonstration

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
Personal Care/Attendant Services Total:							1222760.40
Traditional Personal Care ☐		Per 15 minutes	4	2300.00	3.00	27600.00	
Self Directed Personal Care ☐		Per Month	35	12.00	2845.62	1195160.40	
Private Duty Nursing Total:							1904014.00
PDN RN ☐		Per Hour	11	1429.00	42.00	660198.00	
PDN LPN ☐		Per Hour	28	1169.00	38.00	1243816.00	
Medical Supplies Total:							55500.00
Medical Supplies ☐		Monthly	37	12.00	125.00	55500.00	
Pest Control Service Total:							2500.00
Pest Control Service ☐		As needed	1	1.00	2500.00	2500.00	
Specialized Medical Equipment Total:							133440.00
Specialized Medical Equipment ☐		As needed	16	1.00	8340.00	133440.00	
GRAND TOTAL: 3318214.40 Total: Services included in capitation: Total: Services not included in capitation: 3318214.40 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 41477.68 Services included in capitation: Services not included in capitation: 41477.68 Average Length of Stay on the Waiver: 345							

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
Personal Care/Attendant Services Total:							1259443.80
Traditional Personal Care	☐	Per 15 minutes	4	2300.00	3.09	28428.00	
Self Directed Personal Care	☐	Per Month	35	12.00	2930.99	1231015.80	
Private Duty Nursing Total:							1961134.42
PDN RN	☐	Per Hour	11	1429.00	43.26	680003.94	
PDN LPN	☐	Per Hour	28	1169.00	39.14	1281130.48	
Medical Supplies Total:							57165.00
Medical Supplies	☐	Monthly	37	12.00	128.75	57165.00	
Pest Control Service Total:							2575.00
Pest Control Service	☐	As needed	1	1.00	2575.00	2575.00	
Specialized Medical Equipment Total:							141566.56
Specialized Medical	☐	As needed				141566.56	
GRAND TOTAL: 3421884.78 Total: Services included in capitation: Total: Services not included in capitation: 3421884.78 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 42773.56 Services included in capitation: Services not included in capitation: 42773.56 Average Length of Stay on the Waiver: 345							

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment			16	1.00	8847.91		
GRAND TOTAL: 3421884.78 Total: Services included in capitation: Total: Services not included in capitation: 3421884.78 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 42773.56 Services included in capitation: Services not included in capitation: 42773.56 Average Length of Stay on the Waiver: 345							

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
Personal Care/Attendant Services Total:							1297202.40
Traditional Personal Care	☐	Per 15 minutes	4	2300.00	3.18	29256.00	
Self Directed Personal Care	☐	Per Month	35	12.00	3018.92	1267946.40	
Private Duty Nursing Total:							2019865.56
PDN RN	☐	Per Hour	11	1429.00	44.56	700438.64	
PDN LPN	☐	Per Hour	28	1169.00	40.31	1319426.92	
Medical Supplies Total:							58878.84
GRAND TOTAL: 3520165.61 Total: Services included in capitation: Total: Services not included in capitation: 3520165.61 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 44002.07 Services included in capitation: Services not included in capitation: 44002.07 Average Length of Stay on the Waiver: 345							

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Supplies	☐	Monthly	37	12.00	132.61	58878.84	
Pest Control Service Total:							2652.25
Pest Control Service	☐	As needed	1	1.00	2652.25	2652.25	
Specialized Medical Equipment Total:							141566.56
Specialized Medical Equipment	☐	As needed	16	1.00	8847.91	141566.56	
GRAND TOTAL: 3520165.61 Total: Services included in capitation: Total: Services not included in capitation: 3520165.61 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 44002.07 Services included in capitation: Services not included in capitation: 44002.07 Average Length of Stay on the Waiver: 345							

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
Personal Care/Attendant Services Total:							1336161.80
Traditional Personal Care	☐	Per 15 minutes	4	2300.00	3.28	30176.00	
GRAND TOTAL: 3625730.57 Total: Services included in capitation: Total: Services not included in capitation: 3625730.57 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 45321.63 Services included in capitation: Services not included in capitation: 45321.63 Average Length of Stay on the Waiver: 345							

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Self Directed Personal Care	☐	Per Month	35	12.00	3109.49	1305985.80	
Private Duty Nursing Total:							2080377.55
PDN RN	☐	Per Hour	11	1429.00	45.89	721344.91	
PDN LPN	☐	Per Hour	28	1169.00	41.52	1359032.64	
Medical Supplies Total:							60645.96
Medical Supplies	☐	Monthly	37	12.00	136.59	60645.96	
Pest Control Service Total:							2731.82
Pest Control Service	☐	As needed	1	1.00	2731.82	2731.82	
Specialized Medical Equipment Total:							145813.44
Specialized Medical Equipment	☐	As needed	16	1.00	9113.34	145813.44	
GRAND TOTAL: 3625730.57 Total: Services included in capitation: Total: Services not included in capitation: 3625730.57 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 45321.63 Services included in capitation: Services not included in capitation: 45321.63 Average Length of Stay on the Waiver: 345							

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
Personal Care/Attendant Services Total:							1376259.40
Traditional Personal Care	☐	Per 15 minutes	4	2300.00	3.38	31096.00	
Self Directed Personal Care	☐	Per Month	35	12.00	3202.77	1345163.40	
Private Duty Nursing Total:							2142984.77
PDN RN	☐	Per Hour	11	1429.00	47.27	743037.13	
PDN LPN	☐	Per Hour	28	1169.00	42.77	1399947.64	
Medical Supplies Total:							62466.36
Medical Supplies	☐	Monthly	37	12.00	140.69	62466.36	
Pest Control Service Total:							2813.77
Pest Control Service	☐	As needed	1	1.00	2813.77	2813.77	
Specialized Medical Equipment Total:							150187.84
Specialized Medical Equipment	☐	As needed	16	1.00	9386.74	150187.84	
GRAND TOTAL: 3734712.14 Total: Services included in capitation: Total: Services not included in capitation: 3734712.14 Total Estimated Unduplicated Participants: 80 Factor D (Divide total by number of participants): 46683.90 Services included in capitation: Services not included in capitation: 46683.90 Average Length of Stay on the Waiver: 345							