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 §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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

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

Skilled Nursing Service (RN/LPN) -

Home Modification Services -

Assistive Technology and Durable Medical Equipment(DME) -

Personal Emergency Response System (PERS)Installation -

Personal Emergency Response System (PERS) Monthly Monitoring Fee -

Medical Supplies -

Supervisory Visit -

Partial funding for these services will come from the Agency's approved spending plan for ARP 9817 funds.

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

1. Request Information (1 of 3)

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

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

Alabama Home and Community -Based Waiver for the Elderly and Disabled 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.0068
Waiver Number:AL.0068.R08.00
Draft ID: AL.023.08.00

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

Regular Waiver

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

10/01/22

Approved Effective Date: 10/01/22

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 in42 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 §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A 1915(b) PCCM-E application was submitted on 6/25/2018 and approved by CMS. The Integrated Care Network (ICN) services were implemented October 1, 2018.

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

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

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

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

A program operated under §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 §1915(i) of the Act.

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

A program authorized under §1115 of the Act.
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Elderly and Disabled (E&D) Waiver is to provide home and community-based services to elderly and disabled individuals in the community who would otherwise require nursing facility level of care. The Alabama Medicaid Agency serves as the administering agency for this Waiver and the Alabama Department of Senior Services serves as the Operating Agency.

The Elderly and Disabled (E/D) 1915(c) Waiver runs concurrently with Alabama's 1915(b) Waiver. This allows Alabama to provide a comprehensive form of case management to waiver recipients by contracting with a PCCM-E Integrated Care Network (ICN) to promote a person-centered case management delivery system integrating the medical and Long Term Care Services and Supports (LTSS) needs of waiver recipients in the least restrictive setting of their choice. The ICN manages the case management program, provides case management training, conduct outreach and education and reviews claims as needed. The ICN receives a monthly capitated payment inclusive of HCBS Case Management. The ICN's aim is to:

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

The services currently provided under the E&D Waiver are: Case Management, Personal Care, Homemaker Services, Respite Care (skilled and unskilled), Companion Services, Adult Day Health, and Home Delivered Meals.

The state is proposing to add the following new services: Skilled Nursing (RN/LPN), Home Modification, Assistive Technology and Durable Medical Equipment, Personal Emergency Response System (PERS) installation and monthly Fees, Medical Supplies, and Supervisory visits.

This 1915(c) Waiver includes a consumer directed care initiative called Personal Choices, under the authority of a 1915 (j) State Plan option. This State Plan option gives individuals the opportunity to have greater involvement, control and choice in identifying, accessing, and managing their long term services and community supports. The Program allows self-direction for Personal Care, Homemaker, Unskilled Respite, and Companion services. All participants are given the opportunity to choose between the Personal Choices under the 1915(j) State Plan or traditional waiver services under the E&D 1915(c) Waiver.

The Alabama Medicaid Agency (AMA) is currently working toward directly contracting with one FMSA vendor to be used for all Alabama's HCBS Waiver Programs through the release of a Request for Proposal (RFP). AMA anticipates the release of the RFP for the provision of this service will occur during this waiver renewal period. Until AMA assumes responsibility of the FMSA contact, the Operating Agency will continue to contract with a FMSA vendor for the Elderly and Disabled Waiver program.

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 §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 §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

Not Applicable

No

Yes

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

No

Yes

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

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

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

5. Assurances

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

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

   1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

   2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

   3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. **Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

   1. Informed of any feasible alternatives under the waiver; and,

   2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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:

The Alabama Medicaid Agency (AMA) met the requirements of 42 CFR 441.304 by performing the three (3) activities. On May 4, 2022, a tribal notice was mailed via certified mail to the Tribal Government informing the tribe of Alabama Medicaid's intent to submit a Elderly and Disabled Waiver renewal application to CMS to renew the current waiver with effective dates of October 1, 2022 through September 30, 2027. On May 5, 2022 a Public notice and the application was uploaded to the Alabama Medicaid website [Version AL.023.08.00]. On May 5, 2022, an electronic copy of waiver version AL.023.08.00 was sent to the following:

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

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

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

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

The public comment period ended June 8, 2022. AMA received two (2) public comments:

1. Alabama Disabilities Advocacy Program (ADAP) recognized the addition of new services to the waiver however were concerned about the lack of staff and providers to provide the service.

AMA is actively engaged with the OA and the ICN to improve outreach and education. AMA, in collaboration with the OA, is involved in the Direct Service Workforce Recruitment and Retention Strategies AG initiative to improve recruitment and retention of the workforce. The ICN is conducting an analysis of subcontractor's staffing and pay to determine barriers. It is AMA's goal that through these initiatives, improvements will be made in provider adequacy and staffing.

2. Hendrick Foundation requested changes to the provision and structure of waiver services that could accommodate an Independent Living Community. AMA met with Mr. Hendrick to hear his concerns. Also, Mr. Hendrick submitted comments in writing. AMA is researching this request.

The public comments have not impacted changes to the current waiver application.

AMA collaborated with the OA and ICN during this renewal process. Comments were received from both entities. Some comments were incorporated in the waiver renewal application and others were discussed as points of clarity.

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:

Lee-Jackson

First Name:

Sylisa

Title:

Health Systems Manager

Agency: Alabama Medicaid Agency

Address: 501 Dexter Avenue

Address 2: P.O. Box 5624

City: Montgomery

State: **Alabama**

Zip: 36103

Phone: (334) 353-4599 **Ext:** **TTY**

Fax: (334) 353-4182

E-mail: Sylisa.lee-jackson@medicaid.alabama.gov

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

Last Name: Stone

First Name: Jean

Title: Assistant Commissioner

Agency: Alabama Department of Senior Services

Address: 201 Monroe Street, RSA Tower Suite 350

Address 2: P.O. Box 301851

City: Montgomery

State: **Alabama**

Zip: 36130-1851

Phone: (334) 353-8288 **Ext:** **TTY**

Fax:

(334) 242-5594

E-mail:

Jean.Stone@adss.alabama.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §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: Ginger Wettingfeld

State Medicaid Director or Designee

Submission Date: Sep 14, 2022

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

Last Name: Azar

First Name: Stephanie

Title: Commissioner

Agency: Alabama Medicaid Agency

Address: P.O. Box 5624

Address 2:

City: Montgomery

State: **Alabama**

Zip: 36103

Phone: (334) 353-3399 **Ext:** **TTY**

Fax: (334) 242-5097

E-mail:

Stephanie.azar@medicaid.alabama.gov

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver will be subject to any provisions or requirements included in the state's most recent and approved home and community-based (HCBS)setting Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan. Additionally, for this waiver, the state assures that no setting will be utilized that is not either: (1) fully compliant with the requirements of the HCBS Settings Rule; or (2) an HCBS setting approved prior to March 17, 2014 that has a state-approved transition-to-compliance plan in place which will bring the setting into full compliance with mandatory requirements, as described in the CMS Recalibrated Strategy, by March 17, 2023, and for the remaining requirements, if the state requests and receives approval for a corrective action plan, the state assures that all settings will be fully compliant within the CMS-approved timelines.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Regarding the second performance measure under Assurance G, sub-assurance d, the following language is a continuation of the numerator and denominator due to text box limitations:
"address health concerns of a participant, including any change in a participant's status that could jeopardize their health & safety in the community/D: #participant recs reviewed]"

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Alabama Department of Senior Services (ADSS) and the PCCM-E Intergrated Care Network (ICN), Alabama Select Network (ASN)

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

The Elderly and Disabled (E&D) Waiver is administered by the Alabama Medicaid Agency (AMA)and operated by the Alabama Department of Senior Services (ADSS) and the Integrated Care Network (ICN) known as Alabama Select Network (ASN). AMA exercises administrative discretion in the management and supervision oversight of the Operating Agency and the ICN through policies and procedures, and federal and state regulations. AMA partners with the ICN through a five year RFP released in 2018, effective October 1, 2019. AMA is currently in year four (4) of the Request for Proposal (RFP).

The ICN, through contract agreement, is responsible for case management, training of case managers, outreach and education, and Case Management expenditure review.

The Operating Agency(OA) is responsible for, through an administrative contract agreement, eligibility and enrollment of participants, billing of non-case management service claims, and joint training of providers and staff.

AMA also assumes the responsibility of: (1) Conducting joint trainings (as needed) to providers; (2) Providing periodic training to discuss policies and procedures to consistently interpret and apply policies related to the E&D Waiver Program; (3) Conducting ad hoc, weekly, monthly and/or quarterly meetings to disseminate, clarify, and monitor program operations; (4)implementation of policies and procedures; (5) reviewing audit activities. These activities assist the state to ensure federal and state guidelines are followed in accordance with the approved waiver.

Appendix A: Waiver Administration and Operation

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

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

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

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

AMA contracts with a PCCM-E, an Integrated Care Network (ICN) known as the Alabama Select Network (ASN) for the provision of enhanced case management, case management training, and program oversight. Through the 1915(b) Waiver, the ICN receives a capitated per member per month payment for 1915(c) Waiver case management activities. The ICN subcontracts and reimburses the HCBS case management provider known as the Area Agencies on Aging (AAA).

Based on the provisions within the 1915(j) State Plan Program, waiver participants are given the opportunity to self-direct personal care services through the Personal Choice option, 1915(j). This option is administered through ADSS. Currently, ADSS contracts with a FMSA contractor to perform the required tasks in accordance with Section 3504 of the IRS CODE and Revenue Procedure 70-6. The FMSA contractor assists waiver participants who have chosen to self-direct services with, enrolling employees, completing national background checks on potential Personal Choices employees at no expense to the recipient, addressing all applicable payroll taxes of Personal Choices employees, and processing payroll to include paying the employees. The FMSA contractor is paid a flat rate per month per participant. A fee of 15% of the budget is used to fund the counselor and the FMSA fee. The monthly rate of an initial enrollee is slightly higher for the first month to accommodate the cost of the background screening and enrollment.

AMA is currently working toward directly contracting with one FMSA vendor to be used for all Alabama HCBS Waiver Programs through the release of a Request for Proposal (RFP). Bringing the contract in-house will allow for: greater oversight, continuity of service provision across all spectrums of waivers, and statewide FMSA services to be under direct administration and authority of the AMA. AMA anticipates the release of the RFP for the provision of this service will occur during this waiver renewal period and AMA will submit an amendment to the approved waiver for CMS to consider. Until AMA assumes responsibility of the FMSA contract, the Operating Agency will continue to contract with a FMSA vendor for the Elderly and Disabled Waiver Program.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

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

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

The Operating Agency (ADSS) and the ICN (ASN), contracts with Alabama's 13 Area Agencies on Aging (Triple AAAs) to execute case management. The ADSS and the ASN monitor the AAAs for compliance with guideline and performance as outlined in the approved waiver and authoritative documents.

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

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

Appendix A: Waiver Administration and Operation

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

The Operating Agency (OA) and the Integrated Care Network (ICN) assesses the performance of contracted and/or local/regional non-state entities.

The OA performs audits of the Area Agencies on Aging (AAA) and the local/regional non-state entities to ensure compliance with federal and state regulations.

The ICN performs audits of the AAA to monitor compliance with federal and state regulations.

Alabama Medicaid Agency (AMA) Quality Division assesses the performance of the OA, the AAA's,and the local/regional non-state entities by monitoring compliance with federal and state regulations.

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:

AMA meets these objectives by conducting, at a minimum, an annual audit of the OA. Nurse reviewers conduct the review using a random sampling methodology to review recipient records to ensure:

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

The general objectives of the audits are:

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

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

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

OA documentation of quality assurance (QA) visits to DSP are audited to ensure:

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

OA complaint and grievance procedures are reviewed to ensure:

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

Visits to client homes may be done to determine:

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

Appendix A: Waiver Administration and Operation

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

applies):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of data reports specified in the agreements, policies and procedures with the Medicaid Agency that were submitted on time and in the correct format by the OA. NUMERATOR [Number of data reports provided timely and in the correct format]/DENOMINATOR [Number of data reports due]

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of requested reports submitted by the PCCM-E reviewed and validated by the designated AMA Program Manager for program compliance. NUMERATOR [Number of PCCM-E submitted reports reviewed and validated by the AMA Program Manager for program compliance] / DENOMINATOR [Number of reports submitted by the PCCM-E]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly and Ad Hoc Reports submitted by the PCCM-E, as documented in the AMA

Program Manager Log

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

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 90% with a margin of error of 10%
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:

	Other Specify:	

Data Aggregation and Analysis:

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

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

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

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

Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 90% with a margin of error of 10%
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of total reported performance measures that were above 86%. NUMERATOR [Number of reported performance measures that were above 86%]/DENOMINATOR [Number of reported performance measures]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance measure reporting tool

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

Data Aggregation and Analysis:

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA programmatic operating procedures submitted for review, as documented in the AMA Program Manager Log

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*each that applies):*	
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

The Alabama Medicaid Agency (AMA) exercises administrative authority and responsibility of all performance measures. AMA conducts ad hoc meetings to disseminate policies, rules and regulations, and to review systems performance in efforts to ensure consistent data sharing, applications, collections, and reporting.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method 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.

AMA monitors the Quality Improvement Strategy (QIS)of the waiver on an ongoing basis. If a problem is identified, AMA sends a notice to the OA addressing the issue(s) and require a plan of correction and/or corrective measures to resolve any/all problems identified.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

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

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

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

The Elderly and Disabled (E&D) Waiver requires all clients to meet the nursing facility level of care.

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

Not applicable. There is no maximum age limit

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

Specify:

N/a No Age limit.
System would not submit without entry here.

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	15000
Year 2	15000
Year 3	15000
Year 4	15000
Year 5	15000

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	12355
Year 2	12355
Year 3	12355
Year 4	12355
Year 5	12355

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	
Nursing Facility Transition Assistance	

Purposes	
HIV/AIDS Waiver Transition	

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):*

Nursing Facility Transition Assistance

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The Operating Agency (OA) has estimated that 25 slots/year would be the amount needed to place in reserve for the individuals transitioning from the nursing facility to the waiver.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

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):*

HIV/AIDS Waiver Transition

Purpose *(describe):*

These slots are reserved for individuals who HCB services would have been provided under the HIV/AIDS Waiver.

Describe how the amount of reserved capacity was determined:

Reserve Capacity initiated 10/1/2017 based on termination of Waiver #40382. Reserve capacity remains for this target population.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	20
Year 5	20

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:

Selection of entrants to the elderly and Disabled Waiver is based on a medical and financial determination. The physician must certify nursing home level of care using the nursing home level of care criteria. All recipients receiving waiver services under the Elderly and Disabled Waiver must meet Medicaid's financial guidelines of Medicaid eligibility. Electronic signatures are permissible on all waiver forms for service.

The date of application and the need for services is determined through an assessment process completed by the case manager, the nurse reviewer, and the applicant's physician.

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)*:

§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)

Low income families with children as provided in §1931 of the Act

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 §1902(a)(10)(A)(ii)(XIII)) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (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 §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 §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).
Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §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 §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 (SSI 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 §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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 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:

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

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

The state uses post-eligibility rules for the period between January 1, 2014 and September 30, 2023 or other date as required by law.

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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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 §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 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:

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

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 §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

The state is using post-eligibility rules for the period January 1, 2014 through September 30, 2023 or other date as required by law. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

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

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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:

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

Other

Specify:

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:

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.

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:

All recipients on the Elderly and Disabled Waiver are monitored through at least one monthly face-to-face visit by the case manager. The monthly face-to-face visit is the minimum monthly contact. Monitoring of participants is conducted more frequently if there is a change in the participants medical condition or if there is a change in the participants environmental circumstances. The frequency of other waiver services is based on the needs of the waiver recipient and is documented in the recipient's person-centered care plan.

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 a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

Initial Evaluations are performed by the OA nurse consultants who are registered nurses with current State of Alabama nursing license.

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

The admission criteria is as follows:

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

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

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

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

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

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

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

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

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

J. Comatose client receiving routine medical treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided an individual Level of Care (LOC) evaluation. The case managers submit a Home and Community Based Waiver (HCBS-1) application to the nurse reviewer on staff at the Operating Agency to evaluate and make the level of care determination. The nurse reviewers evaluate the application to make sure it is complete, supports the need for waivers services, establishes the risk of nursing home placement and the medical criteria is met and level of care is approved. The approval of the appropriateness of admission or continued eligibility is assessed from the documentation as per the HCBS-1 assessment tool and other documents which may include physician progress notes, and/or hospital records. A review not only includes meeting the level of care criteria as developed by the Alabama Medicaid Agency but also the assessment of the support systems within the home, the functional limitations of the recipient, the diagnosis and any factors that would place the recipient at risk of institutionalization. Medicaid may also assist with difficult LOC evaluations.

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

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

Reevaluations of eligibility for the Elderly & Disabled (E&D) Waiver must be completed every twelve months. This process is the same as the initial application packet which includes a new level of care, and person-centered care plan (PCCP). Reevaluations must be done on a timely basis so that services and payments will not be interrupted. Billing for Waiver services is bounced against the Waiver Service Long Term Care Benefit Plan, and if eligibility for waiver services is current, the claim is paid. The Alabama Medicaid Agency will not back date reevaluations not received in a timely manner.

All recipients enrolled in the E&D Waiver must have an annual re-determination of need for the nursing facility level of care (LOC) to continue to qualify for services through these waivers. The first re-determination of need for the LOC is to be made within a year of the individuals initial determination.

PROCEDURE:

1.The Case Manager must complete the re-determination application, the HCBS Medical Form, Form 204/205 when applicable, and obtain medical documentation to support the re-determination. This documentation may include hospital notes, lab, x-rays, etc., to support the diagnosis and may also include the most recent 6 months to 1 year of physician office notes. The Case Manager will route this packet of information to the Operating Agency Nurse Reviewer to determine the Level of Care (LOC).

If the application requires Medicaid financial approval, the Operating Agency Nurse Reviewer will complete the level of care evaluation and forward a copy of the Waiver Medical Form/Waiver Slot Confirmation Form (Form 376) to the case manager who will submit the packet to the Alabama Medicaid District Office for processing. The Medicaid District Office will issue a financial award notice or denial notice. ADSS will receive nightly data files with notification of the approvals/denials. Once the Operating Agency receives the financial award notice the application will be processed into the LTC Admission Notification software.

The Operating Agency (OA) may submit an early re-determination application as early as 90 days before the annual re-determination date. Applications received prior to 90 days of the annual date will be returned. All re-determinations must be completed before the LOC segment date expires.

If the re-determination does not process due to an error beyond the control of the OA or AMA (IT glitches, appeal process, etc), the waiver participant will not be disenrolled from the program. Waiver services will continue and be paid upon the receipt of the claim. The OA will request AMA to manually make these changes as directed by the policy and procedures.

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

All evaluations and reevaluations are maintained for a minimum period of three (3) years. The participant's records are located at the OA and the Case Management Agencies.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants who have a Level of Care (LOC) evaluation completed prior to entry into the HCBS Waiver. 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:
Record reviews, off-site; 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 & percent of applicants for whom there is reasonable indication that services may be needed in the future who have a LOC evaluation completed. N [Number of applicants for whom there is reasonable indication that services may be needed in the future who have a LOC evaluation completed/ D[Number of applicants for whom there is reasonable indication that services may be needed in the future]

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
HCBS application and enrollment data

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

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

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

Agency		
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

The Alabama Medicaid Agency (AMA) has granted the Operating Agency's (OA) nurse consultant the authority to make the level of care (LOC) determinations and annual redeterminations (reevaluations). The AMA nurse reviewer will randomly select a percentage of applications for a monthly retrospective review. The AMA nurse reviewer will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes when necessary, and/or any other documentation to support the participant's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (reevaluation) must be completed every twelve months.

The process is the same as for an initial evaluation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method 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.

AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. Individual problems are addressed though re-education and re-training. AMA also conducts ongoing monitoring through data analysis, trends, and meetings. Consumer satisfactions surveys are completing to determine recipient satisfaction. Complaints identified during data collection are handled by requesting the entity involved to follow-up with a recipient until resolution. Plans of correction may be implemented to address non-compliance issues.

Egregious non-compliant issues are addressed differently and on case by case bases. The State will contact the Operating Agency upon receipt of notification and establish a 24 hour action plan.

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):*
	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).

Freedom of Choice is being informed of feasible alternatives under the waiver and having the choice to make decisions about the services and where to receive services. As part of the assessment and service coordination visit, recipients and/or responsible parties are provided with adequate information to make an informed decision regarding the care the recipient wants to receive and the place of service. Care coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the recipient, both formal and informal, as well as the types of waiver services which may be available to meet the recipient's needs and to include those needs which cannot be met.

The Freedom of Choice process allows case managers to inform applicants of available direct service providers and allows the recipient freedom of choice of providers; and the choice of either institutional or home and community based services. Each waiver recipient must make a written choice for either institution or community care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the recipient is not capable of signing the form and does not have a designated caregiver. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

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

The forms are maintained in the recipient's Case Record.

Appendix B: Participant Access and Eligibility

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

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

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators, the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanics are the only significant LEP population in the State of Alabama at 3.59%.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Health With Transportation
Statutory Service	Case Management
Statutory Service	Homemaker
Statutory Service	Personal Care
Statutory Service	Skilled Respite
Other Service	Adult Companion Service
Other Service	Adult Day Health Without Transportation
Other Service	Assistive Technology and DME
Other Service	Home Delivered Meals
Other Service	Home Modification
Other Service	Medical Supplies
Other Service	Personal Emergency Response System (PERS) Installation
Other Service	Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly
Other Service	Pest Control Services
Other Service	Skilled Nursing
Other Service	Supervisory Visit
Other Service	Unskilled Respite

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health With Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Adult Day Health with transportation is a service that provides Elderly and Disabled Waiver clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. Transportation between the individuals place of residence and the Adult Day Health center can be provided as a component of Adult Day Health service.

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

A unit of service is a minimum of four (4) hours a day. If transportation is provided for the recipient, the four(4)hour minimum for a participant includes transportation time, lunch breaks or free time. The number of units authorized per visit and the transportation component must be stipulated on the person-centered care plan and the Service Authorization Form. A unit is defined as a per diem rate. If transportation is included, the provider will bill a higher per diem rate that will include the cost of the transportation.

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

Participant-directed as specified in Appendix E

Provider managed

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 Business License

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health With Transportation

Provider Category:

Agency

Provider Type:

Vendor with Business License

Provider Qualifications

License *(specify)*:

Agency must have a license to conduct business in Alabama
Drivers must have a valid Driver's License
Nurses must have a current license by the Alabama Board OF Nursing.

Certificate *(specify)*:

None

Other Standard *(specify)*:

Director must have a high school diploma or equivalent. The employees must comply with AMA's current TB testing policy. Nurses shall have preferably at least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

Initially at contract execution and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Case Management Services is a waiver service available to all Elderly and Disabled Waiver clients to assist individuals in gaining access to appropriate, needed, and desired services, as well as needed medical, social, and educational resources regardless of the funding source. Case Management Services can be performed by Case Managers with a Bachelors of Art or Bachelors of Science Degree from an accredited college or university preferably in a human services related field, a Registered Nurse licensed by the Alabama Board of Nursing, and a Licensed Practical Nurse licensed by the Alabama Board of Nursing. As part of case management, assessments and developments of person-centered care plans (PCCP) are completed. Waiver and non-waiver services are monitored to ensure the recipients' needs are being met and to determine changes in health conditions. Case Management Services allows for the provision of collaboration with health care providers to improve health outcomes. Also, Case Management Services provides an avenue to transition a recipient from an institutional setting, such as hospital and nursing facilities back into community. The ICN reviews the Case Management Services and pay the providers based on AMA and ICN contract agreement. All Case Management activities shall be documented in the Case Management Software according to the timeframe identified by AMA.

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

Case Management service provided prior to waiver approval should be considered administrative. At least one monthly face to face visit is required in addition to any other Case Management activities. There is a maximum limit of 180 days under the Elderly and Disabled Waiver to assist an individual to transition from an institution to a community setting. During this period, it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor. For Transitional Case Management, a unit of service that assists individuals transitioning from institutional settings into the community is fifteen (15) minutes beginning on the first date the Case Manager goes to the institution to complete an initial assessment. If Transitional Case Management is provided, it should not be billed until the first day the recipient is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the Elderly and Disabled Waiver,reimbursement will be at the administrative rate.
Case management is provided according to the need of the recipient as documented in the Care Plan. Waiver recipients shall receive at least one face to face case management visit monthly.

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

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

Participant-directed as specified in Appendix E

Provider managed

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	Area Agencies on Aging

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Area Agencies on Aging

Provider Qualifications

License *(specify):*

If the Case Managers are practicing in a nurse or social worker role, they shall have a current Nursing License by the Alabama Board of Nursing or a license by the Alabama Board or Social Work.

Certificate *(specify):*

Other Standard *(specify):*

Case managers can be individuals with a Bachelor of Arts or Bachelor of Science Degree from an accredited college or university. The employees must comply with AMA's current TB testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Alabama Medicaid Agency

Frequency of Verification:

Degrees shall be verified at initial hire. License shall be verified at initial hire and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	08 Home-Based Services	**Sub-Category 1:**	08050 homemaker
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Homemaker service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing. Homemaker can also be provided as a participant -directed service under the state plan option.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the person-centered care plan.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self Directed Homemaker Employee
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Self Directed Homemaker Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self Directed Homemaker Workers:
* Must have at least two references, one from work and/or school, and one personal, which have been verified by the individual or family (with or without the support of a consultant).
* Must have background checks required by law and regulation
* Must be at least 18 years of age
* Must be able to read and write and understand instructions, as verified by the individual or family.
* If providing transportation, must have valid driver's license and insurance as required by State Law
Training Requirements
This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s). The family must be trained on the types of incidents to report, who to report to and the timeframes to report any incidents.
Basic elements of training shall be provided prior to the worker delivering services and includes:
Procedures and expectations related to the Homemaker including following the Plan of Care,
the rights and responsibilities of the worker and the individual, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and the Operating Agency. In addition and as needed, training in the following areas
will be provided by the family or others and recorded.
a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) If administration of ordinarily self-administered medication is required by the individual, training and ongoing supervision in medication administration.
c) Training as needed in communication skills; in understanding and respecting individual choice and direction; in respecting the individual's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d). Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual and identified by the plan of care.
e). Training on the types of incidents and incident reporting is required.
Supervision
Supervision of the self-directed personal care workers is the responsibility of the family and/or the individual.
Documentation
The family and individual must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly. These records are necessary for audits performed by CMS, Medicaid, AAAA and the Operating Agency. Daily or weekly logs, signed by the worker and by the individual or family member, which identify the individual, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Homemaker Workers Financial Management Services Workers will be employed by the family and participant, who will be employers of record. The family and individual will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the Homemaker workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per Homemaker worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care, Homemaker and Unskilled Respite).
The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:
a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

None

Other Standard *(specify):*

Homemakers shall be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The employees must comply with AMA's current TB testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Home Care Agency

Frequency of Verification:

Initially at contract execution and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	**Sub-Category 1:** 08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Personal Care Services provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the clients family. Personal Care Services is not an entitlement. It is based on the needs of individual client as reflected in the PCCP.

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

Personal Care Services is direct care provided in the client's residence. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the client's plan of care. The amount of time authorized does not include the Personal Care Worker's transportation time to or from the client's residence, or the worker break or mealtime. A unit is defined as fifteen (15) minutes. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self Directed Personal Care Employee
Agency	Home Health Agency or Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Self Directed Personal Care Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self Directed Personal Care Workers:

* Must have at least two references, one from work and/or school, and one personal, which have been verified by the individual or family (with or without the support of a consultant).
* Must have background checks required by law and regulation
* Must be at least 18 years of age
* Must be able to read and write and understand instructions, as verified by the individual or family.
* If providing transportation, must have valid driver's license and insurance as required by State Law

Training Requirements
This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s). The family must be trained on the types of incidents to report, who to report to and the timeframes to report any incidents. Basic elements of training shall be provided prior to the worker delivering services and includes:
Procedures and expectations related to the personal care worker including following the Plan of Care, the rights and responsibilities of the worker and the individual, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and regional office. In addition and as needed, training in the following areas will be provided by the family or others and recorded.
a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) If administration of ordinarily self-administered medication is required by the individual, training and ongoing supervision in medication administration.
c) Training as needed in communication skills; in understanding and respecting individual choice and direction; in respecting the individual's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d). Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual and identified by the plan of care.
e). Training on the types of incidents and incident reporting is required.

Supervision
Supervision of the self-directed personal care workers is the responsibility of the family and/or the individual.

Documentation
The family and individual must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly. These records are necessary for audits performed by CMS, Medicaid, and/or ADSS/AAA monitors and auditors. Daily or weekly logs, signed by the worker and by the individual or family member, which identify the individual, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Personal Care Services Financial Management Services

The self-directed personal care workers will be employed by the family and participant, who will be employers of record. The family and individual will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the personal care workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per personal care worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care, Homemaker and Unskilled Respite).

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:
a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency or Home Care Agency

Provider Qualifications

License *(specify):*

Business License with the state of Alabama

Certificate *(specify):*

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

Other Standard *(specify):*

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by the Commissioner of the Medicaid Agency. The Personal Care worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training per calendar year is also required. The employees must comply with AMA's current TB testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Certification Surveyor
Area Agency on Aging

Frequency of Verification:

Annually upon initial approval by AMA, annually, and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:

Category	Sub-Category
Category 1: 09 Caregiver Support	**Sub-Category 1:** 09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope)*:

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Skilled Respite

Provider Category:

Agency

Provider Type:

Home Health Agency or Home Care Provider

Provider Qualifications

License *(specify)*:

Business License to practice in Alabama
Certificate of Need if Home Health Agency
Registered Nurse and Licensed Practical Nurse with current Licensure by the Alabama Board of Nursing.

Certificate *(specify)*:

None

Other Standard *(specify):*

This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing or a Licensed Practical Nurse with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a LPN in public health, hospital, home health, or long term care nursing. The LPN must work under the supervision of an RN. The employees must comply with AMA's current TB testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Companion Service

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

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

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the care plan.

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

Companion Service is direct service provided to the client. The number of units per visit must be indicated on the PCCP and the Service Authorization Form. The amount of time authorized does not include the Companion Workers transportation time to or from the clients home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the client. A unit is defined as fifteen (15) minutes.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self Directed Employee
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Service

Provider Category:

Individual

Provider Type:

Self Directed Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self Directed Companion Workers:
* Must have at least two references, one from work and/or school, and one personal, which have been verified by the individual or family (with or without the support of a consultant).
* Must have background checks required by law and regulation
* Must be at least 18 years of age
* Must be able to read and write and understand instructions, as verified by the individual or family.
* If providing transportation, must have valid driver's license and insurance as required by State Law
Training Requirements
This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s). The family must be trained on the types of incidents to report, who to report to and the timeframes to report any incidents.
Basic elements of training shall be provided prior to the worker delivering services and includes: Procedures and expectations related to the Companion worker including following the Plan of Care, the rights and responsibilities of the worker and the individual, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and the Operating Agency. In addition and as needed, training in the following areas will be provided by the family or others and recorded.
a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) If administration of ordinarily self-administered medication is required by the individual, training and ongoing supervision in medication administration.
c) Training as needed in communication skills; in understanding and respecting individual choice and direction; in respecting the individual's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d). Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual and identified by the plan of care.
e). Training on the types of incidents and incident reporting is required.
Supervision
Supervision of the self-directed Companion workers is the responsibility of the family and/or the individual.
Documentation
The family and individual must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly. These records are necessary for audits performed by CMS, Medicaid, AAAA and the Operating Agency. Daily or weekly logs, signed by the worker and by the individual or family member, which identify the individual, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Companion Workers Financial Management Services Workers will be employed by the family and participant, who will be employers of record. The family and individual will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the Companion workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per Companion worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care, Homemaker and Unskilled Respite).
The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:
a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Service

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program.
All Companion workers must have at least six (6) hours in-service training per calendar year.
The employees must comply with AMA's policy for TB testing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

standards and requirements are to be verified at hire, annually, and as needed thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Health Without Transportation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 04 Day Services	**Sub-Category 1:** 04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Adult Day Health without transportation is a service that provides Elderly and Disabled Waiver clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. If transportation between the individuals place of residence and the Adult Day Health center is provided by someone other than the Adult Day Health, transportation service is not a component of the per diem rate and the provider will bill the lesser rate.

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

A unit of service is a minimum of four (4) hours a day. If transportation is not provided for the recipient, the provider will bill the lesser rate for a four(4)hour minimum for a participant, lunch breaks or free time. The number of units authorized per visit must be stipulated on the person-centered care plan and the Service Authorization Form. A unit is defined as a per diem rate.

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

Participant-directed as specified in Appendix E

Provider managed

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: Adult Day Health Without Transportation

Provider Category:

Agency

Provider Type:

Vendor with a Business License

Provider Qualifications

License *(specify):*

Alabama Business License
Valid Alabama Driver's License
Nurses with current Alabama Board of Nursing license

Certificate *(specify):*

None

Other Standard *(specify):*

Have a valid Alabama Driver's license if transportation Adult Day Health clients, possess a valid, picture identification; all Adult Day Health workers must have at least six (6) hours in-services training per calendar year. The employee must comply with AMA's current TB Testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

Standards verified at the initial contract execution, annually and as needed thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology and DME

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Assistive Technology - Assistive Technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities. Assistive Technology also includes any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. This service must be necessary to maintain a recipient safely in the community. All items shall meet applicable standards of manufacture, design and installation. The Elderly and Disabled Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A providers medical records must substantiate the need for the service, findings and information shall support medical necessity. Assistive Technology can include, but are not limited to wheelchairs, reachers, Hoyer lift, bath benches, etc. The service may also be provided to assist an individual to transition from an institutional level of care to the Home and Community-Based Waiver and shall be documented in the Plan of Care and the case narrative.

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

Assistive Technology must be ordered by the physician. The case manager must have the prescription for Assistive Technology and the prescription shall be maintained in the case file. This item requires prior authorization and approval by the OA. The maximum allowed for this service $2,000 per year per waiver recipient up to a total of $10,000 per waiver participant's lifetime. A unit is defined as an item. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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 Alabama Business License

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and DME

Provider Category:

Agency

Provider Type:

Vendor with Alabama Business License

Provider Qualifications

License *(specify):*

Vendor with Alabama business license

Certificate *(specify):*

Other Standard *(specify):*

Vendor is responsible for orientation to the equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

At contract execution and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category	Sub-Category
Category 1: 06 Home Delivered Meals	**Sub-Category 1:** 06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope)*:

Home Delivered Meals are provided to an eligible waiver participant who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the participant can be addressed by the provision of home-delivered meals. This service will not constitute a full nutritional regimen (Federal statute prohibits board from being reimbursed by Medicaid).

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

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

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

Provision is based on the needs of the individual, and the unit(s) of service needed will be specified in the PCCP. The unit of service is one (1) package of seven meals. The maximum number of meals authorized per week is 14,

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

Participant-directed as specified in Appendix E

Provider managed

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 Food Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Licensed Food Vendor

Provider Qualifications

License *(specify)*:

Driver of truck must have a valid driver's license

Certificate *(specify)*:

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Verified initially at contract execution and monitored annually and as needed thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

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

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

Limits on Home Modifications are $5,000 per recipient per lifetime. Any expenditure in excess of $5,000 must be approved by the Operating Agency. This item requires prior authorization by the OA. Home Modifications are excluded from rental properties unless a temporary modification such as a modular ramp is needed and there is documentation that the modification is approved by the landlord. A unit is defined as an item.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Individual

Provider Type:

Licensed Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medical Supplies

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Medical Supplies - Medical supplies include those supplies necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies may, but are not limited to, diapers, chux, gauze, and catheters. Medical supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc. A prescription shall support the need for medical supplies. Medical supplies shall be documented in the care plan.

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

Medical supplies provided under this Waiver must be prescribed by a physician, and be specified in the Plan of Care. 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. Medical supplies shall be billed monthly, quarterly or annually. The yearly allotment cap shall not exceed $1,200.00 If billed monthly, the monthly cap amount shall not exceed $100.00. If billed quarterly, the quarterly cap amount shall not exceed $300.00. Total cap amounts shall not rollover to another month, quarter or year. A unit is defined as an item. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Medical Equipment and Service Providers

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:

Home Medical Equipment and Service Providers

Provider Qualifications

License *(specify):*

Business license to practice in Alabama and meet state laws for the provision of services in Alabama.

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service will be those who have signed provider agreements with the Alabama Medicaid Agency, and the OA. The case manager must provide the participant with a choice of vendors in the local area of convenience.
Licensure is by the Alabama Board of Home Medical Equipment Services Providers. Providers of this service must meet the same standards required for the providers under the Alabama
State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS) Installation

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

PERS is an electronic device that enables high-risk recipients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a recipient's phone or internet service and is programmed to signal a response center once a "help" button is activated. This service will cover the installation fee. By providing recipients immediate access to assistance, PERS serves to prevent institutionalization.

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

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, without an available caretaker increasing health and safety risk. The price quotation from the vendor shall specify the description of the PERS. Only one installation per recipient can be approved. Exception to this limitation shall be considered on an individual basis for circumstances such as relocations. The need for PERS shall be documented in the care plan.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Authorized PERS vendor

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Authorized PERS vendor

Provider Qualifications

License *(specify):*

Trained professional licensed to conduct business in the state of Alabama

Certificate *(specify):*

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

Other Standard *(specify):*

The PERS provider should assure that devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent. The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.
PERS Minimum Requirements:
1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response.
2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person centered plan or PERS parameters.
3) A call tree that reflects the person's needs and preferences.
4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and Accountability Act (HIPAA) and all other data privacy laws and requirements.
5) Address the documented risk factors and preferences of the person.

Verification of Provider Qualifications

Entity Responsible for Verification:

Prior Authorization by:
Operating Agency

Frequency of Verification:

At initial service contract implementation and as needed to replace device

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly

HCBS Taxonomy:

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

14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

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

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

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

This service will cover the monthly fee after the PERS system has been installed. The response center shall be staffed by trained professionals. Initial setup/ installation and monitoring of PERS must be documented in the care plan.

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

The price quotation from the vendor providing the service shall specify the description of the PERS. A unit is defined as a monthly rate.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Authorized PERS Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly

Provider Category:

Agency

Provider Type:

Authorized PERS Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

At initial contract agreement, annually, and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control Services

HCBS Taxonomy:

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

Pest Control service is the chemical eradication of pest by a professional in a waiver participant's primary residence.

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

Pest Control Service may be provided in a waiver participants' primary residence, which could be:
a participant living in his /her own private home or apartment who is responsible for his/her own rent or mortgage; or a participant living with a primary caregiver.

Pest Control Service include the following activities:
a)Assessment or inspection
b)Application of chemical based pesticide
c)Follow up visit

Pest Control Service 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 participants' 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. A unit is a series.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pest Control Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Services

Provider Category:

Agency

Provider Type:

Pest Control Company

Provider Qualifications

License *(specify):*

State of Alabama Business License
Licensed and Certified

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

At initial contract agreement, annually, and as needed thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a registered nurse or licensed practical nurse who will perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing. Skilled Nursing Services is provided based upon the needs of the Elderly and Disabled Waiver participant. The Skilled Nursing Service is to provide skilled medical monitoring, direct care, and intervention for an individual with skilled nursing needs to maintain him/her through home support and is not intended to be provided seven (7) days a week/24 hours a day. This service is necessary to avoid or delay institutionalization. Services listed in the service plan or plan of care which are within the scope of the State's Nurse Practice Act. A RN is required to perform the supervisory visit every 60 days for a LPN providing this service. The RN completes an in-home assessment to determine if the services may be safely and effectively administered in the home. This assessment also will identify the need for service and the amount of time needed. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. The registered nurse establishes a nursing care plan complying with the plan of treatment. The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by a licensed practical nurse (LPN). LPNs may provide skilled care for the recipient if a licensed physician prescribes the service. The LPN works under the supervision of the RN. The RN evaluates the participant and establishes the Nursing Plan of care prior to assigning services to the LPN.

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

A unit of service is one hour of direct skilled nursing care provided to the client. The waiver participant must exhaust all use of home health/State Plan benefits before receiving Skilled Nursing services under the Elderly and Disabled Waiver. The provision of Skilled Nursing Services must be ordered by a physicians and documented in the plan of care. Services provided without an order by the physician will not be reimbursed by the Alabama Medicaid Agency. Skilled Nursing Services shall not be provided seven (7) days a week/24 hours a day. Skilled Nursing is not intended to be a private duty arrangement. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify)*:

The Home Care Agency must have a Business License to practice in the state of Alabama. Nurses (RN and LPN) employed by the Home Care Agency must have a valid license to practice nursing in the state of Alabama issued by the Alabama Board of Nursing

Certificate *(specify)*:

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

Other Standard *(specify)*:

the workers must comply with AMA's policy for TB testing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Home Care Agency
Operating Agency

Frequency of Verification:

Nursing licenses are renewed annually. Exclusion lists are viewed monthly and require documentation that the check was completed. Waiver provider certification occurs prior to Contract Approval, annually, and as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supervisory Visit

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	11 Other Health and Therapeutic Services	**Sub-Category 1:**	11010 health monitoring
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

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

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

Supervisory Visits shall be billed in 15 minutes increments not to exceed 60 minutes or 4 increments every 60 days. No reimbursement will be made for attempted or missed visits. One increment is defined as 15 minutes. State plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.
Partial funding for this service comes from the Agency's approved spending plan for ARP 9817 funds.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supervisory Visit

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

Nurses license shall be verified at initial hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Unskilled Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unskilled Respite

Provider Category:

Individual

Provider Type:

Self Directed In Home Unskilled Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite Care Workers:
*Must have background checks required by law and regulation.
*Must be at least 18 years of age.
*Must be able to read and write and follow instructions.
*Must have at least completed tenth grade.
*Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
*Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person.

Verification of Provider Qualifications

Entity Responsible for Verification:

The self-directed Unskilled workers will be employed by the family and participant, who will be employers of record. The family and individual will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the Unskilled workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per Unskilled worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care, Homemaker and Unskilled Respite).

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:
a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unskilled Respite

Provider Category:

Agency

Provider Type:

Home Health Provider or Home Care Agency

Provider Qualifications

License *(specify):*

License to conduct business in Alabama.

Certificate *(specify):*

Certificate of Need if the Agency is a Home Health Agency.

Other Standard *(specify):*

This service will be performed by non licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision. Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker. The employees must comply with AMA's policy for TB testing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency
Area Agency on Aging

Frequency of Verification:

Prior to Contract agreement, annually and as needed thereafter.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

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

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

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be

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

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

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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 (Appendix C-2-c) 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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.*

Under traditional personal care, 1915(c) a legal responsible individual many not provide personal care, however under the 1915(j) Personal Choices State Plan option, a legal responsible individual many provide personal care if the legal responsible individual meet the requirements as outlined in the 1915(j) Personal Choices State Plan option.

Self-directed

Agency-operated

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.

As permitted through the 1915j SPA

Other policy.

Specify:

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

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared and mailed. After the package is returned, it is reviewed for completeness of information. The Operating Agency or designee (AAA) will conduct an initial on-site visit to verify that the provider is in compliance with Medicaid Waiver standards and regulations before approval as a direct service provider is made. Each new provider is also required to attend a waiver training conducted by the OA.

When all information from the potential provider has been reviewed and verified, a financial amount is established and a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement allowing provider to provide unskilled services. This request is based on the OAs (or designee) review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent new contract providers who met initial licensure and/or certification standards, other standards established by Medicaid & applicable requirements of state laws prior to service provision. N:Num. new contract provider who met init. lic - cert standards, other standards established by Medicaid and/any appl reqs of statelaws prior to service provision. D:All new/contract providers

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of existing contracted providers that continue to meet licensure and/or certification standards,other standards established by Medicaid/any applicable requirements of state law. N:Numbe of existing contracted providers that continued to meet lic-cert standards, other standards established by Medicaid/applicable requirements of state law. D:Number of existing contracted providers

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

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

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: 100% of provider training verification records are reviewed over a two year cycle

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

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers that meet waiver compliance requirements. NUMERATOR [Number of non-licensed/non-certified providers that meet waiver compliance requirements]/DENOMINATOR [Number of non-licensed/non-certified providers]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider records on-site and off site

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

		Sample Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	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 percent of providers that meet training requirements in accordance with state requirements and the approved waiver. NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver]/DENOMINATOR [Number of providers]

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

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	100% of provider training verification records are reviewed over a two year cycle

Performance Measure:
Number and percent of currently enrolled self-directed providers who continue to meet waiver training requirements. NUMERATOR [Number of currently enrolled self-directed providers that continue to meet waiver training requirements]/DENOMINATOR [Number of currently enrolled self-directed providers]

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of new self-directed employees that meet waiver training requirements. 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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method 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 Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings as needed with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, and (3) Conducting quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs.

AMA has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the E&D Waiver Quality Assurance Strategy relevant to the identification, remediation and documentation methods : (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources: reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participants homes, conducting consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection and require the entity involved to submit a plan of correction with 15 days of notification. If resolution of non-compliance is not documented within the approved timeframe, the OA and/or the Medicaid Agency entity will take any additional actions needed, which may include technical assistance, continued monitoring, modification of the corrective action plan, recoupment and/or provider disqualification. All action steps, timelines and final resolution status are identified and documented in the corrective action plan; and (4) Collect data and submit quarterly and annual reports to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvement.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.
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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. The only provider owned or operated settings in the E&D waiver are for Adult Day Health (ADH) programs. Due to the constraints of the COVID-19 Public Health Emergency, at the time the state submitted its STP on 7/31/22, the State had not been able to confirm any of the settings were fully compliant, but anticipates all of the ADH programs will reach compliance within the required timeframes.
2.For purposes of ascertaining that settings achieve and maintain compliance, the state modified its ADH program audit tool and processes to incorporate the assessment of Final Rule compliance on an annual basis. The audit tool questions and protocols are designed to evaluate policies and procedures, as well as the actual experience of the individuals participating in the programs. As such, it allows the State to assess the current level of compliance and identify any areas of noncompliance on the individual program and systemic levels. In addition, the state will continue to offer technical assistance to support the maintenance of compliance over time.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Care Plan (PCCP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Social Worker
Specify qualifications:

Other
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *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.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

The PCCP development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources. 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 shall be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers are included on the PCCP. The PCCP must be reviewed at a minimal of every 60 days and updated at a minimal, annually, in the presence of the participant to make sure services are appropriate for participant's needs. In limited extenuating circumstances these may be completed by virtual or remote means as dictated by policy.
Electronic signatures are permissible on waiver forms for service.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. Once a referral is received, the Case Manager makes a face-to-face visit with the client for evaluation and completion of the Home and Community-Based Services (HCBS) application. To clarify the assessment information, the Case Manager may consult with the recipient and caregiver as applicable, and physician regarding the medical, behavioral, functional, and social information and needs.

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

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

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

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

d. The care plan is developed according to needs identified during the assessment process in collaboration with identified medical needs addressed by the physician. Each case will be monitored monthly through contacts and at least one face-to-face visit with the recipient. Special emphasis will be put on discussion of the clients 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. Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing clients according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

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

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

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

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

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

(c) Documentation of any change in a PCCP will be maintained in the client's file.

(d) If the total number of hours of service is changed, a new Service Authorization is required from the Case Manager.

(e) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(f) If an individual declines waiver services or has become ineligible for services, a Service Authorization Form indicating termination is required from the Case Manager.

(g) A new Service Authorization is required following each redetermination of eligibility, even if there are no changes to the authorized services.

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 the participants safety are addressed in the development of the Person-Centered Care Plan (PCCP). Plans are individualized and should take into consideration the participants rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participants health and welfare is reviewed, the PCCP adjusted accordingly and evaluated for appropriateness.

During the monthly visit, the Case Manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the PCCP. The case manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered to have a potential risk the Case Manager may visit more often to monitor the situation to ensure the participants health and safety is not jeopardized. When a risk has been reported or identified, a home visit to monitor the health and safety of the client is required as soon as it can be arranged.

The case managers calls the participate to determine changes in conditions and to ensure needs are being met in the community.

Additionally, Direct Service Providers (DSP) staff must visit the participants home as ordered in the PCCP. DSPs are trained and expected to observe and report any concerns about a participants health and welfare to the Case Manager and in writing to supervision of the DSP agency.

DSP have policy/procedures established for serving clients in the event the assigned worker is unable to provide the service. As part of this back-up protocol, the DSPs are notified of clients who may be a potential risk so that the case manager will be able to give them first priority when service visits must be temporarily prioritized and/or reduced by the DSP.

Prior to initiating a service authorization, the case manager must contact the provider to determine the start date and discuss any special needs the recipient may have. An emergency backup plan is considered if visits are not made. In cases where the recipient is determined to be in jeopardy if visits are missed, the authorization will be flagged when initiated. If the risk status changes, the existing authorization is revised and sent to the provider indicating the current status.

An emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a client who would be vulnerable during the emergency/disaster:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Prior to assessment for the Elderly and Disabled Waiver program, the case management staff screens the applicant for their desire for waiver participation and their likelihood to meet financial and level of care eligibility criteria. These activities are preliminary requirements for waiver enrollment and are distinct from case management activities but are included in this scope of service and are recorded as administrative activities. These activities are documented in the case record.

The intake and screening process is involved and must include documentation regarding the following:

a. The applicant has been informed about the application process;

b. The applicant has been informed of all direct service providers and allowed his or her freedom of choice of providers;

c. The applicant has been informed of all HCBS Programs of which he or she may benefit and allowed freedom of choice of programs;

d. The applicant has been informed of choice options regarding case management services;

e. The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the client is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The reason for the absence of a signed choice should be well documented in the case record. Signatures with the mark of an X are accepted followed by a statement mark of recipients name and the mark must be witnessed. If the applicant is physically impaired to the extent that he or she is unable to sign for him or herself, the legal representative may sign the form as follows: Jack Jones signed by Joe Scott. It must be clearly documented why the applicant did not sign.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

The ICN and the OA conduct audits on Area Agencies on Aging (AAA)to review PCCP and the quality of service delivery for persons receiving waiver services. If discrepancies relating to the PCCPs, quality of service delivery, or noncompliance with other state and federal guidelines related to service delivery are identified during either the review, the audited entity is notified in writing and is given the opportunity to resolve or clarify the discrepancies or provide a Corrective Action Plan (CAP). The audit may result in recoupment of Medicaid funds.

AMA, the ICN, and the Operating Agency meet weekly to review program operation issues, quality assurance, and provide administrative oversight. Quarterly, AMA, the ICN,the Operating Agency, and the AAA meet to reviw case managements issues, program administration, and to discuss operation issues.

D-1-G requires the state to describe the process by which the person-centered service plan, under which waiver services are furnished, is subject to approval by the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i). The state’s primary methodology requires the Operating Agency to submit the person-centered plan procedures and format to AMA for review and approval. All person-centered plans must be completed using the approved procedures and format. The Appendix D performance measures are then used to evaluate various aspects of the implementation of the approved person-centered plan procedures and format. It is correct that the Appendix D performance indicators are based on a sample size in accordance with the 95% confidence interval with a +/- 5% margin of error. These performance indicator data are derived from audit processes of the Operating Agency and the PCCM-E as indicated in the waiver application. However, for purposes of a secondary validation, AMA also completes an oversight audit of the Operating Agency’s work in this area, which is based on a sample size in accordance with the 90% confidence interval with a +/- 10% margin of error. These two levels of review provide ample data to confirm the person-centered plans are completed in the manner approved by the Medicaid Agency.

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 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:

The Participant-Centered Care Plan (PCCP) must be reviewed every 60 days in the presence of the recipient to make sure services are appropriate and meets the recipient’s needs. The PCCP must be updated, at a minimal, annually and when there is a changed in the recipient's condition or needs.

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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The entity responsible for monitoring the implementation of the Person-Centered Care Plan (PCCP) and participant's health and welfare is the case management staff of the Area Agencies on Aging (AAA). This is done during the face-to-face visit. Special emphasis is put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal supports are included on the PCCP.

The PCCP must be reviewed every 60 days in the presence of the participant to ensure that services are appropriate for the participant's needs. Participant's and/or responsible relatives shall be instructed to notify the Case Manager if services are not initiated as planned, or if the participant's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the PCCP. The Case Manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services included in the plan. The DSP must receive documentation regarding the specific needs and desires of the participant and the specific tasks to be performed. Information included on the Service Authorization Form must be clear, specific, accurate and include the number of units or hours of service per day and the number of days per week which are authorized.

The Operating Agency (OA) conducts random home visits to monitor PCCP and assess the health and welfare of participants.

The supervisor of the Direct Service Providers agency has a responsibility to contact case management staff immediately by telephone when services cannot be provided to a participant who may be have health and safety risk if services are not provided as outlined in the PCCP.

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

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

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. NUMERATOR [Number of participant service plans that address all participant's assessed needs, including health and safety risk factors]/DENOMINATOR [Number of participant service plans reviewed]

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

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

Performance Measure:
Number and percent of participants whose service plans address all of the participant's personal goals. NUMERATOR [Number of participants whose service plans address all of the participant's personal goals]/DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
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% confidence level with a +/- 5% margin of error
Other Specify: PCCM-E	**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: PCCM-E	**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 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 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 that include the signatures of the required participants in the development of the plan as indicated by the approved waiver]/DENOMINATOR [Number of PCCP's reviewed]

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

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

		95% confidence level with a +/- 5% margin of error
Other Specify: PCCM-E	**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: PCCM-E	**Annually**
	Continuously and Ongoing
	Other Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the***

waiver participants needs.

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 whose needs changed and whose service plans were revised accordingly]/DENOMINATOR [Number of participants whose needs changed that were reviewed]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
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% confidence level with a +/- 5% margin of error
Other Specify: PCCM-E	**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: PCCM-E	**Annually**
	Continuously and Ongoing
	Other Specify:

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

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

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

Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify: PCCM-E	**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: PCCM-E	**Annually**
	Continuously and Ongoing
	Other

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

Performance Measure:
Number and percent of participants whose service plans are updated at least annually. NUMERATOR [Number of participants whose service plans were updated at least annually]/DENOMINATOR [Number of participants reviewed]

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record reviews on-site; 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% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Record reviews on-site; 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% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Record reviews on-site; 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% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Record reviews on-site; 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% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Record reviews on-site; 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% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other	**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 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):
Other
If 'Other' is selected, specify:
Participant interviews, 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 Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

e. ***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 that have a signed freedom of choice form that specifies that choice was offered among services and providers. NUMERATOR [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among services and providers]/DENOMINATOR [Number of participant records reviewed]

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

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

Performance Measure:
Number and percent of service plans that document the waiver participant was offered and made a choice between traditional and self-directed care. NUMERATOR [Number of service plans that document the waiver participant was offered and made a choice between traditional and self-directed care]/DENOMINATOR [Number of participant service plans reviewed]

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

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

		95% confidence level with a +/- 5% margin of error
Other Specify: PCCM-E	**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: PCCM-E	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of participants interviewed that answered "yes, all services" to

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

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

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

Data Aggregation and Analysis:

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

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

The Alabama Medicaid Agency(AMA) has granted the Operating Agency (OA) the authority to develop Person-Centered Care Plans. AMA Quality Division will conduct retrospective record reviews quarterly. The Quality Division reviews a percentage of case management records on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method 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 Agency(AMA)exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of:(1) Conducting joint trainings 2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver Program,(3) Conducts meetings as needed to disseminate policies, rules and regulations regarding the Home and Community-Based Waiver Program. Also, AMA has developed a Quality Management Strategy for the Elderly and Disabled Waiver Program. If individual problems are identified, the entity involved shall submit a CAP within 15 calendar days of notification of the request.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Other Specify: PCCM-E	**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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Participants of the Elderly and Disabled Waiver 1915 (c) will be able to access services in two ways: Option one is the traditional Elderly and Disabled waiver services 1915(c). Option two is the Personal Choices Program, a State Plan Option, 1915(j) of the Social Security Act, which provides an alternative to the traditional provision for personal care services and affords the participants an opportunity to direct and manage their own services to the extent they are able.

Services available for Participant Direction services under Personal Choices Program State Plan Option, 1915(j) are: Personal Care, Homemaker, Unskilled Respite, and Companion. Skilled Nursing is not an allowable service under the 1915(j) because the provisions do not fall within the guidelines of the Alabama Nurse Practice Act.

Participants may choose to manage their own personal support plans, or may appoint one representative to assist them to assume budget and care management responsibilities. The representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plan or may be appointed during the duration of the waiver.

The State delegates the responsibility for developing the self-directed personal assistance service under the State Plan Option, 1915(j)to the counselors employed by the designated Operating Agency and does not delegate any portion of that authority to any other Medicaid State Plan service provider. If a recipient chooses Personal Choices State Plan Option 1915(j), the counselor provides a comprehensive training to ensure the participant has the information needed to make informed decisions about their services. The counselor also informs the recipient of their ability to change providers if they are not satisfied with a chosen provider's performance and provides training on the budget process before the individual budget is developed. The training and technical assistance 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 Counselor will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest. The representative can be a spouse of the participant. The counselor trains, coaches, and provides technical assistance to participants as needed while receiving services under the State Plan Option. Activities and counselor services provided by the counselor and forms completed by the counselor shall be documented and housed in the Case Management Software. The counselor ensures that timesheets are submitted in a timely manner to facilitate appropriate reimbursement.

The identified worker cannot be an individual receiving services through the Personal Choices Program or receiving services on any Home and Community-Based Waiver Program.

Training materials are developed and modified as needed, based upon the participant’s level of competency. Training materials are to be reviewed and approved by AMA.

Once the waiver participant/representative has identified a candidate for hire, he/she will submit the completed application and all required documentation to notify the Financial Management Services Agency (FMSA) of their choice of workers for consideration of employment. The FMSA will assist the participant and/or representative to facilitate employment of a worker. The FMSA will have the candidate complete an application for employment and will perform a national background check/screening at no expense to the recipient for each candidate prior to employment and provision of service. Once the results of the national background check/creening have been completed, the FMSA will inform the waiver participant/representative of the status and whether the candidate is eligible for hire.

The review and approval of timesheet will be the responsibility of the waiver participant. The workers will submit completed timesheets directly to the FMSA in an Electronic Visit Verification System (EVVS) to be processed for payment by the FMSA. The FMSA is responsible for monitoring all invoices for services.

Also, the FMSA conducts the following tasks: development an enrollment packet for individuals that will provide services; perform background checks at no cost to the participant on prospective individuals who will provide services; and manage and monitor on a monthly basis, all invoices from individual employees who provide waiver services against the amount of services authorized in a particular plan of care and the spending plan. Also, the FMSA develops fiscal accounting and expenditures reports, report problems regarding participant directed services to the Personal Choices Counselor, work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's, withhold federal, state, and local tax payments including FICA, file the necessary tax forms for the IRS and the State of Alabama, provide the individual with the necessary tax information on a timely basis, file and withhold state unemployment insurance tax, and make payments for invoices submitted by individuals or agencies providing services.

The FMSA is monitored at least every two years by the OA.

Th participant can, at any time, voluntary disenroll by contacting their counselor of such a decision. The counselor will begin the disenrollment process and work with the case manager to transition the participate to traditional waiver services under the 1915(c)Waiver. The case manager provides support and services and works closely with the counselor to ensure continuity of care if the recipient chooses to transition to a traditional waiver service under the 1915(c) Waiver.

The Case Manager monitors the provision of participant-directed services, 1915 (j), through monthly home visits to ensure services are delivered and health and safety is not compromised.

Design Elements of the Quality Management Plan for Personal Choices 1915(j) includes accountability. The Alabama Medicaid Agency (AMA) maintains administrative oversight responsibilities for the Quality Management Plan. The Alabama Department of Senior Services (ADSS)/Operating Agency is responsible for the actual management of quality activities defined in the plan. The ADSS maintains primary oversight of monitoring the Counselor/FMSA to the degree necessary to ensure compliance with participant direction of their care and appropriate fiscal and programmatic procedures; identifing modifications and applying edits to the Personal Choices data system to create reports, prevent erroneous billing and allow a continual system of review; provide support to the Counselor and FMSA to enable effective training.

The Quality Improvement Committee (QIC) monitors all aspects of quality in the Personal Choices Program 1915(j). The QIC members consist of Medicaid and Operating Agency staff. This committee will set performance indicators, review program operations and results make recommendations for program changes and develop strategies for program improvement.

ADSS/Operating Agency monitors aspects of the Personal Choices Program 1915(j) to assure compliance with the program requirements. The OA conducts participant surveys to monitor the level and quality of participant direction and the adequacy of the training curriculum to enable successful participant direction. ADSS responds to possible quality problems identified through any channel by establishing a Project Team to examine the available data, study the work process in question, and develop a corrective action plan. The OA shall maintain a current handbook of Personal Choices services. The handbook shall be reviewed and updated at least annually. Recipient education materials, revisions to the handbook, and recipient training materials shall be approved by AMA.

The Project Team includes a representative from AMA's Long Term Care Quality Review Unit. ADSS, along with the Project Team will monitor implementation of changes and subsequent data collection to determine whether problems have been resolved. Program changes are reviewed during the quality meeting with the OA.

The Performance Indicators are used to measure program performance that may occur at the service or provider level. The Performance Indicator Reports describes the results of data gathered using the Performance Indicators, the source of the data, the frequency in which the data is reviewed, and who assists in analyzing the data.

Incident Management and Abuse Prevention are completed by performing criminal background checks of providers at no cost to the participant or the proposed worker.

The OA serves as the Incident Management Review team and are tasked with the quarterly review of all incident reports. OA staff develops recommendations or changes to the program, and monitor the program changes to ensure implementation. The OA reviews and manages incidents, complaints, or grievances on an ongoing basis and follows established guidelines for reporting and follow-up as set forth by AMA. In addition, findings are reported at the Operating Agencies quarterly quality meeting.

The state assures that an evaluation will be provided to CMS every three years, describing the overall impact of this State Plan Option 1915(j) on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services under the traditional waiver 1915(c).

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Participant: Employer Authority. As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Participants of the Elderly and Disabled Waiver 1915 (c) will be able to access services in two ways: Option one is the traditional Elderly and Disabled Waiver services (1915(c). Option two (2)is the Personal Choices Program, a State Plan Option, 1915(j) of the Social Security Act, which provides an alternative to the traditional provision for personal care services and affords the participants an opportunity to direct and manage their own services to the extent they are able. Each participant will be provided a choice between the traditional vendor 1915(c) or the Personal Choices State Plan Option 1915(j).

The state has the following safeguards to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence. The state delegates the responsibility for developing the self-directed personal assistance service plan to the counselors employed by the designated OA and does not delegate any portion of that authority to any other Medicaid State Plan service provider.

Participants who elect to self-manage but run into difficulty with managing services will be supported by the counselor to resolve issues and identify methods by which the participant can continue to manage his/her own care. However, a representative may be required for continued enrollment if efforts at resolution fail to correct the issues.

A representative can be a friend, caregiver, family member, or other trusted person. Representation may be required if a participant has a legally recognized, court-appointed representative or legal guardian. However, the participant may still be supported to participate in Personal Choices decision-making and management to the extent he/she wishes to do so. A designated representation must:

Show a strong personal commitment to the participant
Show knowledge about the participant's preferences
Be willing and able to meet all program requirements listed of the participant
Be at least 18 years old
Be willing to submit to criminal background checks, if requested
NOT be known to abuse drugs or alcohol
NOT have any history of physical, mental or financial abuse

If the recipient chooses not to continue to self direct services under the State Plan 1915(j) option, the counselor will assist the recipient to transition to traditional waiver services under the 1915(c) waiver. The counselor will work with the case manager to ensure continuity of care between service provisions.

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.

Participants are required to attend an orientation to the Personal Choices 1915(j) Participant Handbook prior to the disbursement of the initial monthly budget. The intent of the orientation is to provide participants with the tools they need to effectively and safely manage their services.

Counselors are responsible for providing this mandatory training session for participants enrolled in the program. Participants will receive a program manual to provide additional information to support the training objectives.

During this orientation, risks are identified and risk mitigation plans are developed through the use of three primary tools:

1) Personal Choices Rights and Responsibilities
2) Self-Assessment
3) Risk Assessment Checklist

Participants are provided the Personal Support Plan tool, to assist them in identifying others resources who may be able to provide help and support and thereby also mitigate risk. Participants also uses the Personal Support Plan tool in the development of a back-up plan.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

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

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

Participants may also receive assistance with their Personal Choices responsibilities without appointing a friend, caregiver, family member, or other person as a representative, but these individuals cannot sign documents, speak for or otherwise act on behalf of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Homemaker		
Adult Companion Service		
Unskilled Respite		
Personal Care		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

Governmental entities

Private entities

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

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

The FMSA contracts with the Operating Agency and was selected based upon the State of Alabama's procurement guidelines. The FMSA Agency enrolls as a provider. The FMSA does not provide any direct services. The FMSA operates as a Vendor Fiscal/Employer Agent. The FMSA contractor provides services in withholding, filing and paying federal and state income tax withholding, FICA, FUTA and SUTA in accordance with federal IRS and DOL and State of Alabama Departments of Revenue and Industrial Relations rules and regulations. The FMSA conducts required criminal background checks for all prospective employees of the Personal Choices Program at no expense to the recipient. The FMSA performs all FMSA tasks directly and may not delegate any FMSA tasks to a third party without expressed written permission from the Operating Agency.

During this waiver renewal period, the Alabama Medicaid Agency is proposing to bring the FMSA contract in-house through an Request for Proposal to facilitate continuity of care between all Waiver programs.

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

The FMSA receives a set monthly payment for each participant per month. This cost is estimated at 15% of the participant's budget and part of 15% is directed to the cost of the counselor. When a participant is enrolled for the first time, the first monthly payment is slightly higher to cover the administrative costs.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The OA will monitor the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours. Remediation of the problem will be expected within 48 hours of the FMSA being notified by the operating agency. AMA will be responsible for monitoring this process annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

The counselor and case manager work together in the provision of participant direction of services. The counselor's time is billed as an administrative activity as established through the 1915(j) authority. The counselor provides ongoing information and assistance after the participant chooses to enroll in the self-directed program. This includes education about the program requirements, assistance as needed with the development of the spending plan, ongoing technical assistance, etc. The case manager's time for any information and assistance or support (such as described in the renewal document for assistance in transitioning back to traditional waiver services) provided to the participant who is self-directing their care is billed as a case management service.

Information and Assistance in Support of Participant Direction.
The case manager, in the assessment phase, provides information to the participant so the participant can make an informed decision regarding participant direction of services under the waiver or personal care under the state plan option. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. The case manager's time for any ongoing information and assistance or support provided to the participant who is self-directing their care is billed as a case management service.

Administrative Activity.
The following activities falls under administrative: documentation of case notes, processing of billing and claims, and time in office working on a case. If the participant chooses to disenroll from self-directive services, The counselor and waiver case manager work together to gather the following information in support of the involuntary disenrollment of the participant, to identify and resolve any problems that may enable continued enrollment or confirm that the reasons for involuntary disenrollment cannot be resolved. Both entities will work together to explain the processes and timeline for transfer back to the traditional waiver program.

The Case Manager performs monthly a re-assessment. If health and safety issues are identified, they are addressed and the recipient may be moved back to the traditional waiver, 1915(c), if the client is unable to meet the requirements for participation in the Personal Choices State Plan Option, 1915 (j). The counselor and case manager work together to ensure a smooth transition back to traditional services. The case manager's activities are covered under the case management service.

Waiver Service Coverage.
Information and assistance in support of
participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health Without Transportation	
Personal Emergency Response System (PERS) Installation	
Skilled Nursing	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly	
Homemaker	
Supervisory Visit	
Adult Companion Service	
Assistive Technology and DME	
Skilled Respite	
Pest Control Services	
Home Delivered Meals	
Unskilled Respite	
Case Management	
Adult Day Health With Transportation	
Medical Supplies	
Personal Care	
Home Modification	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The FMSA provides employer related services. These include:

-Performing background checks on prospective individuals who will provide personal care services;
-Managing, on a monthly basis, all invoices for personal care services authorized in the participants' plan of care;
-Developing fiscal accounting and expenditure reports.

The methods and frequency of the FMSA review are as follows:
-The FMSA will provide monthly reports to the Operating Agency.
-The Operating Agency and/or Alabama Medicaid Agency will perform on-site administrative and operational reviews
-Alabama Medicaid Agency and the Operating Agency will monitor the FMSA, on a monthly basis during the first six months of operations and every six
months thereafter.

Information and Assistance in Support of Participant Direction. The case manager, in the assessment phase, provides information to the participant regarding participant direction of services so the participant can make an informed decision regarding personal care under the waiver services and personal care under the state plan option. If the individual elects to direct their own services, they are referred to the Counselor for enrollment in the Personal Choices program. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. The case manager’s time for any ongoing information and assistance or support provided to the participant who is self-directing their care would also be billed as a case management service.

Administrative Activity. Pursuant to the 1915j: The counselor plays a significant role in the overall development of the participant's personal support plan. The counselor assesses supports and needs as well as health and safety risks as required by Elderly and Disabled Waiver protocols. The counselor’s time is billed as an administrative activity. The counselor provides ongoing information and assistance after the participant chooses to enroll in the self-directed program. This includes education about the program requirements, assistance as needed with the development of the spending plan, ongoing technical assistance, coordination with the FMSA, etc.

The counselor also provides support as needed for the participant to successfully self-direct services. However, if the participant chooses to disenroll from self-directive services, the counselor and waiver case manager would work together to support the participant in transitioning back to traditional services. They would gather information in support of the involuntary disenrollment of the participant, to identify and resolve any problems that may enable continued enrollment or confirm that the reasons for involuntary disenrollment cannot be resolved. Both entities will work together to explain the processes and timeline for transfer back to the traditional waiver program.

The Case Manager performs a monthly a re-assessment. If health and safety issues are identified, they are addressed and the recipient may be moved back to the traditional waiver, 1915(c), if the client is unable to meet the requirements for participation in the Personal Choices State Plan Option, 1915 (j). The counselor and case manager would work together to ensure a smooth transition back to traditional services. The case manager’s activities would be covered under the case management service.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

A program participant may elect to discontinue participation in the Personal Choices Program, 1915(j) State Plan Option at any time. The Alabama Medicaid Agency and the Operating Agency will initiate procedures to serve as safeguards to ensure that the reasons for discontinuance are not related to abuse, neglect or similar concerns. It is the responsibility of the participant to initiate voluntary discontinuance by notifying the Counselor of such decision by phone, mail, or e-mail. The counselor will document in the participant's record, the date of notification by the participant of their decision to discontinue in the Personal Choices Program. The counselor will begin the process within 5 business days from the date of notification.

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

From the receipt of the recipient's request to discontinue their participation, the timeline for initiation of traditional waiver services may be from 15 to 45 days. The counselor will have 10 days to begin the process of reinstating traditional waiver services work closely with the case manager of the 1915(c) Waiver to facilitate a continuity of care. Personal Choices Program under the 1915 (j) services will continue until traditional services under the 1915(c) Waiver have been reinstated.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the Personal Choices Program under the 1915(j), the participant will be returned to receiving traditional waiver services under the 1915(c). Participants will be given advance notice in writing of their return to the traditional program. Although the decision to involuntarily disenroll the participant from the Personal Choices Program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on the appeal.

The participant/representative has 30 days from the date of the notification of their return to the traditional waiver program to request an informal review of the decision to disenroll the participant from the Personal Choices Program. The AMA and the OA will make a decision within 30 days from receipt of the request for an informal review.

If the informal review decision is unfavorable, the participant may appeal the decision within 30 days from the date of the written decision of their return to the traditional program in accordance with established Medicaid Fair Hearings provisions.

Participants may be involuntarily returned to traditional waiver services for the following reasons:

-Health, Safety and Well-Being: At any time that case manager, ADSS, ASN, or AMA determines that the health, safety and
well-being of the participant is compromised or threatened by continued participation in the Personal Choices Program, the
participant will be returned to traditional waiver services.

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		12355
Year 2		12355
Year 3		12355
Year 4		12355

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		12355

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The cost of conducting a national criminal background checks is compensated as part of the payment to the FMSA.

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

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

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

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

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

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

Reallocate funds among services included in the budget

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

Substitute service providers

Schedule the provision of services

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

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

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

A. Each participant's budget will be established based on the current hours of traditional waiver services under the 1915(c) Waiver, received each
week. Of the total monthly amount, a portion will be directed to the FMSA for administration of the participant-directed services. The primary
choice for the recipient will be the decision regarding who will provide their services.

B. The number of hours that a participant will receive is based on the individual assessment of need and will remain unchanged, unless the
participant's need changes. All changes will be indicated on the waiver participant's PCCP. Each participant will be provided a form which will
assist in determining the payment methodology and rate of pay for the worker.

C. Services are reviewed for appropriateness monthly during the case management home visit. Any additional factors identified during the home visit
or by other means are based on the assessment of need and will be indicated on the recipient's PCCP.

D. Policies and procedures will describe the formula used to establish each recipient's budget which will be applied consistently for each recipient
who chooses the participant-directed option under the State Plan Option 1915(j).

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 Operating Agency informs each participant receiving services under the State Plan Option 1915(j)of the amount of their monthly budget and the procedures by which to request an adjustment in the budget amount during the development of the personal support plans. Separate orientations to participant direction are provided by the counselor during the home visits. As a result, the potential participants are provided timely information about participant direction to allow them to make an informed decision about whether to enroll in the Personal Choices Program, State Plan Option 1915(j) or receive waiver services through the traditional 1915 (c) Waiver program. For example, potential participants will be informed about the benefits and responsibilities associated with enrollment into the Personal Choices Program.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Personal Choices 1915(j)under the State Plan financial management activities include:
-Identification of problems associated with the monthly allowance such as misuse or under-utilization of the funds;
-Participant/representative's failure to pay staff as required;
-Participant/representative's failure to comply with applicable state and federal laws;
-Participant/representative's failure to submit documentation of expenditures;

Theft of checks mailed to participants or other problems are reported in writing to the AMA and the OA.

The counselor trains,coach and provide technical assistance to participants as needed. The training and technical assistance helps participants use the budget effectively to meet their care needs, avoid overspending as well as to prevent the under utilization of their allocated budget.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As part of assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions. Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

Description of the State's procedures for allowing individuals to choose either institutional or home and community-based services:

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the form and has no legal or responsible party who can sign. In such a situation, services will not be denied just because a written choice statement cannot be obtained. The case manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

Description of how the individual (or legal representative) is offered the opportunity to request a Fair Hearing under 42 CFR Part 431, subpart E.

1. If an individual chooses to appeal the decision, a written request must be submitted to the contact person designated by the OA within 30 days from the date of the notice of action. However, services may continue until the final outcome of the hearing, if the written request is received within 10 days after the effective date of the action.

2. The OA will schedule the Informal Conference, notify the individual by certified mail, and contact the Medicaid Waiver Program Administrator to get the names of the AMA staff that will be attending the conference. The Informal Conference should be scheduled within seven business days of receiving the hearing request.

3. The OA will forward a hard copy of the Informal Conference notification letter to the Medicaid Waiver Program Administrator with the date, time, and place of the Informal Conference or a conference call number, if listed.

4. If necessary, the OA and the Medicaid Waiver Program Administrator may schedule a pre-conference meeting to discuss any pertinent information. This meeting may be face-to-face or by phone.

5. After the Informal Conference, the AMA will review the documentation presented during the Informal Conference with the OA staff. The OA and Medicaid Nurse Reviewer will submit their recommendations in writing to the Medicaid Waiver Program Administrator.

6. The Medicaid Waiver Program Administrator will send a certified letter notifying the individual of the decision. A copy of the letter will be sent to the OA, nurse reviewer, and others as specified.

7. If the individual/guardian is still dissatisfied after the Informal Conference, a Fair Hearing may be requested. A written request for a hearing must be received no later than 30 days from the date of the notice of action. (letter notifying recipient of the Informal Conference outcome).

FAIR HEARING PROCESS

1. When the appropriate Medicaid Waiver Program Administrator receives a written request for a Fair Hearing, the date-stamped envelope is retained, an entry made in a waiver log, a record established, and a copy of the written request is faxed to the OA and the AMA’s Office of General Counsel.

Note: If the request for a Fair Hearing is received by the OA or the AMA

Office of General Counsel, a copy of the written request is faxed to the appropriate Medicaid Waiver Program Administrator.

2. The OA develops a summary packet which will include a full summary, denial notice, and all other pertinent documents related to the action with which the individual/guardian is dissatisfied.

3. Once the summary packet has been prepared, the AMA Office of General Counsel will create a Scheduling Request to be sent to the Administrative Law Judge (ALJ) and copied to the primary witnesses.

4. Once the ALJ has received the Scheduling Request, he/she will create a Scheduling Order. This signed document will confirm the date and time of the hearing and it will be mailed to the individual/guardian, OA, and the AMA. The OA Office of General Counsel will be responsible to prepare and conduct the hearings and the AMA will maintain the responsibility of coordinating and scheduling the hearings, to include the scheduling and coordinating of the ALJ.

5. Once the hearing has been held, the ALJ will make a recommendation and send a copy of the recommendation to the individual/guardian, OA, and the AMA.

6. The OA may provide comments on the recommendation to the AMA Office of General Counsel. After reviewing the recommendations, a concurrence/non-concurrence letter will be signed by the AMA Commissioner and mailed to the individual/guardian, with a copy to the OA.

7. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of federal or state law or policy. However, the state does offer a hearing in these cases.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

The Alabama Medicaid Agency does operate another dispute resolution process, the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a fair hearing. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the case manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing.

At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within thirty (30) days of the date of the notice of action. The document referring to the participants appeal rights is maintained in the waiver participants home for future reference.

During the current waiver, AMA held three (3) informal conferences during waiver year On One(1) and on e(1) informal conference during waiver year four (4). See Attachment E for a summary of additional informal dispute resolutions during the current waiver.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of federal or state law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The following State Agencies are responsible for the operation of the grievance/complaint system:

1. Alabama Department of Senior Services(ADSS)

2. Alabama Medicaid Agency(AMA)

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ADSS is responsible for explaining the procedures to clients of filing complaints and grievances. ADSS must also have procedures in place that will assure AMA that Direct Service Providers(DSP) explained to clients the process on how to register a complaint. Waiver applicants/participants are informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility. ADSS shall provide the participant written information about filing complaints and grievances. The DSP's supervisors will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider, they should forward their complaint to appropriate agency and/or AMA. ADSS shall inform all participants that filing a grievance/complaint is not a prerequisite or substitute for an appeal. Recipients also can file complaints about service provision, quality of care, and access to care.

a. Complaints are submitted to ADSS and AMA are investigated through resolution. Complaints are entered into a web-portal. This web-portal is an
electronic document routing system that is also used to keep track and send alerts on complaints.

b. If complaints are received by AMA, a copy will be forwarded to ADSS within two (2) business days. If they are received by ADSS a copy will be forwarded
to AMA Quality Assurance Division within 24 hours if the client's health and safety are at risk.

c. ADSS must investigate all complaints upon receipt of notification. Appropriate parties must initiate action within 24 hours if it appears that a client's
health and safety is at risk. If necessary, the complainant will be interviewed.

d. If during the investigation it is determine a Corrective Action Plan (CAP) is needed from the provider due to a complaint or grievance, the provider shall
submit the CAP to the OA within 30 calendar of the request for the CAP. The OA will evaluate the CAP within seven (7) business days of receipt. If the CAP
is not responsive to the complaint, it will be returned to the provider within two (2) business days requesting a revised CAP. The revised CAP will be
resubmitted to the OA within two (2) business days. If the revised CAP remains unresponsive, the provider will have up to seven (7) business days to
revise the plan and carry out the appropriate action.

e. ADSS will review all complaints and grievances to determine a patterns and trends to assure that no health and safety risk exist.

f. Final determinations including any adverse findings will be reported to the AMA, Quality Assurance Division.

g. Daily, AMA reviews complaints and grievances in the Case Management Software web portal for tracking, trends, resolutions, and to determine if additional follow-up is
needed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	Immediate
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours
Self-Neglect	Immediate
Missing/Eloped Individual	Immediate
Other	24-hours

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.

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.

Death-the permanent suspension of consciousness and the end of life.

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 but are not limited to, suicide, homicide or other criminal activity, medical error or complication, undiagnosed conditions or accidents, or those that were suspicious for possible abuse or neglect.

Exploitation-the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Moderate Injury- Any observable and substantial impairment of a person’s physical health requiring medical treatment that is not considered a major injury and that does not cause substantial risk of death, permanent disfigurement, or a protracted loss of impairment of the function of a bodily member or organ.

Major Injury- Any observable and substantial injury that is not considered a moderate injury which results in permanent o protracted impairment, such as fractures, wounds requiring more than five (5) sutures, injury to internal organs, burns, or

physical disfigurement of the body. Major injuries typically require medical treatment and may result in hospitalization.

Natural Disaster-the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.

Fire - a situation in which something such as a building or an area of land is destroyed or damaged by burning.

Fall- The sudden and involuntary drop from an upright position to a lower surface or the ground.

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.

Missing/Eloped Individual- A person who cannot be located and there Is reason to believe the person may be lost or in danger.

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 recipients homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human resources, law enforcement authorities, physicians, caregivers individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976
All physicians, osteopaths, chiropractors and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

Other incidents such as falls must be reported within 24 hours to the provider agency, the Alabama Medicaid Agency, and the Alabama Department of Senior Services in a timely manner based upon the circumstances surrounding the incident.

Child Abuse Prevention and Treatment Act 1974
Alabama law is clear on reporting abuse and neglect of children under the age of 18. For example, physicians, teachers, social workers, nurses, day care workers or anyone who comes in contact with suspected child abuse or neglect should make a report to those who can take action. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that a child has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the State Child Abuse Reporting Hotline (334- 242-9500).

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with consumers to encourage them to talk about what is important to them as well as what they do not like. Each recipient is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the recipients rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand, the case manager and the Direct Service Provider (DSP) are responsible for informing the client/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect/or exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Alabama Medicaid Agency serves as the reporting agency for critical events or incidents and Alabama Department of Human Resources serves as the investigative agency. The Alabama Department of Senior Services (ADSS) receives reports of critical events or incidents. All critical events and/or incidents are logged into the Case Management Software web-portal. ADSS investigates critical events and makes a decision regarding if additional action is needed within seven (7) business days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven(7) business days from receipt of the additional information with a response disseminated to all parties involved.

All allegations of abuse require an investigation. The case manager has the primary responsibility for discussing a plan of action for the reported critical incident/event with the participant or guardian. The case manager would discuss the actions taken and any results of the actions due to the findings. The discussion may either be in person or by phone.

The Operating Agency is available to assist as needed and may communicate directly with the participant or guardian regarding an event/incident and any findings or actions taken when necessary. If the Operating Agency determines that an incident requires follow-up, the case manager monitors the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the case manager will seek available resources and make arrangements, when appropriate.

The case manager will discuss the plan of action for findings of the critical incidents/events with the participant or guardian. The case manager will maintain an ongoing dialogue with the participant or guardian during in-person meetings, by phone, or via email until resolution has occurred. The Operating Agency will communicate with the participant or guardian as needed.

Responses to critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

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

The Alabama Department of Senior Services (0perating Agency) is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants through individual/family interviews.

The OA notifies Medicaid's Elderly and Disabled Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken by the coordinator. In addition, Medicaid's Quality Improvement Coordination Unit is responsible for overseeing the reporting of and response to critical incidents through a review of the Case Management Software critical incident dashboard, medical record reviews, DSP personnel record reviews, and onsite home and provider visits, when deemed necessary.
AMA and ADSS will review quarterly reports to identify any trends or concerns. If AMA and ADSS notice areas of concern, the entities will address them by policy changes or education.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

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

The Alabama Department of Senior Services (ADSS), Alabama Department of Human Resources, and Alabama Medicaid Agency is responsible for detecting the unauthorized use of restraints in Alabama by conducting monthly monitoring of participants health and welfare and provider quality reviews. Certain incidents of abuse, neglect and exploitation must be reported to ADHR by law.

The Alabama Medicaid Agency conducts annual reviews of ADSS's investigations.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The Alabama Department of Senior Services (ADSS) is responsible for detecting the unauthorized use of restrictive interventions through monthly face to face visits as well as supervisory visits every 60 days.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

The Alabama Department of Senior Services (ADSS), Alabama Medicaid Agency (AMA), and Alabama Department of Human Resources (ADHR) is responsible for detecting the unauthorized use of seclusion. The ADSS is responsible for detecting the unauthorized use of seclusion through monthly face to face visits as well as supervisory visits every 60 days

ADSS conducts monthly monitoring of participants health and welfare and conducts provider quality reviews.

By law, certain incidences of seclusion are reported to the ADHR.

AMA conducts annual reviews of ADSS's investigations.

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

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

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

Appendix G: Participant Safeguards

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of abuse, neglect, exploitation, or unexpected death incidents reviewed/investigated within the required timeframe. NUMERATOR [Total number of abuse, neglect and exploitation or unexpected death incidents reviewed/investigated within the required timeframe]/DENOMINATOR [Number of abuse, neglect and exploitation or unexpected death incidents]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting and management system

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

	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # & % of closed cases of abuse/neglect/exploitation for which the OA verified that the investigation conducted by the provider was done in accordance with state policy. N: # of closed cases of abuse/neglect/exploitation for which the OA verified that the investigation conducted by the provider was done in accordance with state policy./ D: # of closed cases of abuse/neglect/exploitation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting and management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
 # & % of suspected Abuse, Neglect & Exploitation (ANE) incidents & Unexpected Deaths (UD) referred to appropriate investigative entities, e.g., Adult Protective Services (APS), Child Protective Services (CPS) &/or Law Enforcement (LE). N: # suspected ANE incidents & UD referred to appropriate investigative entities, e.g., APS, CPS &/or LE. / D: # Suspected ANE & UD incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting and management system

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

	Other Specify: Daily	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records that do not identify previously unreported incidents of abuse, neglect, mistreatment, exploitation and unexplained deaths. NUMERATOR [Number of participant records that do not identify previously 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:
Incident reporting and management system; records review, 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 Agency	**Weekly**	**100% Review**

Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] /DENOMINATOR [Number of service providers]

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

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

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify: 100% of provider training verification records are reviewed over a two year cycle

Performance Measure:
Number and percent of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] /DENOMINATOR [Number of case managers]

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

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	100% of provider training verification records are reviewed over a two year cycle

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents that have been resolved by the OA within 60 days of the date of the critical incident report date. NUMERATOR [Number of critical incidents resolved by the OA within 60 days of the date of the critical incident report date]/DENOMINATOR [Number of reported critical incidents]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting and management system

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of critical incident trends where systemic intervention was implemented. 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:
Incident reporting and management system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
 # & % of critical incident trends for which systemic intervention was implemented that showed sustained improvement after 3 months or state implemented corresponding rev to intervention. N: # crit incident trends where syst. int. was implemented that showed sustained improvement after 3 mos or state implemented corresponding rev to int./ D: # crit incident trends for which sys int was implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting and management system

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

	Other Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:

Number and percent of participant records reviewed that do not identify previously unreported incidents of unauthorized restrictive interventions or seclusion. NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] /DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Incident reporting and management system; records review, 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 Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of people who responded that their overall health was Good, Very Good, or Excellent. NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent]/DENOMINATOR [Number of surveys containing responses regarding health reviewed]

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with a +/- 9.8% (Sample size deemed appropriate by NCI)
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:
 # & % participant records that document training & edu. were provided to provider staff on how to identify & address health concerns of a participant, including any change in a participant's status that could jeopardize their health & safety in the community. N:# participant recs that doc. training & edu were provided to provider staff on how to identify & ..(cntnd.in Main B. Optional)

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participants who had an ambulatory or preventive care visit during the year. NUMERATOR [Number of participants who had an ambulatory or preventive care visit during the year]/DENOMINATOR [Number of participants]

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

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

The Case Manager monitors participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager also reports any events of this nature to the waiver administrator in the approved format who will forward to AMA within the required guidelines. The Case Manager tracks reports to resolution for documentation and will report the resolution to the waiver administrator to forward to AMA. Reference Main B, Optional for runout text for PM language for Appendix G sub-assurance "d".

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method 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.

AMA has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of this Strategy relevant to the identification, remediation and documentation methods : (1) Monitor and collect data from Incident Reporting Systems; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participants' homes, conduct consumer satisfaction surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection and require the entity involved to submit a plan of correction with 15 days of notification. If resolution of non-compliance is not documented within the approved timeframe, the OA and/or the Medicaid Agency entity will take any additional actions needed, which may include technical assistance, continued monitoring, modification of the corrective action plan, recoupment and/or provider disqualification. All action steps, timelines and the final resolution status are identified and documented in the corrective action plan; (4) Collect data and submit quarterly and annual reports to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvement; and (5) The Operating Agency (OA) must investigate all high risk health and safety issues upon identification through any of the data sources identified above and/or any other notification and initiate action within 24 hours. The OA must also notify AMA within two (2) working days. If necessary, the recipient and/or Direct Service Provider (DSP) will be interviewed. The OA and AMA will review the issue to determine if there is a pattern of problems and whether any health and safety risks exist. AMA will contact the recipient via telephone to ensure full resolution to the incident has been completed satisfactorily. Any final determinations including any DSP probations and or termination will be reported to the AMA.

ii. Remediation Data Aggregation

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

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

Responsible Party(*check each that applies*):	**Frequency of data aggregation and analysis**(*check each that applies*):
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify: 5% of Medication Administration records are reviewed annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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.

AMA is responsible for collecting data quarterly and annually to determine the quality of services provided from various sources for the Elderly and Disabled Waiver Program. The Quality Framework is used as a guide to assess seven (7) Program Design Focus areas: samples of waiver participants, case management, direct service providers records, on-site home visits (when deemed necessary) and onsite visits to adult day health facilities. Also, consumer satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine clients satisfaction with resolutions.

Data is collected through an annual review of each OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all applicants approved by the AMA is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of case managers and other employees personnel records are reviewed to ensure basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months until they are found to be in compliance.

AMA will evaluate reports and make recommendations for improvements to the program. The AMA will determine if changes are made to the program.
In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access:
Sources of data
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant Centered Service Planning and Delivery:
Sources of data
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities:
Sources of data
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards:
Sources of data
Case Management Records
Consumer Surveys
Home Visits
Site Visits

Participants Rights and Responsibilities:
Sources of data

Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction:
Sources of data
Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance:
Sources of data
Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborated Meeting with Operating Agency to enhance the administration of the Program
Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaids Long Term Care Division:

Percentage of client/family reporting satisfaction with waiver services and needs met.
Percentages of client/family reporting they feel safe and secure in the home and community.
Percentage of client/family reporting they have ready access to services and were informed of sources of support available in the community.
Percentage of client/family reporting knowledge of rights and responsibilities.
Percentage of records indicating services are planned and implemented according to the client needs and preferences.
Evidence that each operating agency has a Quality Assurance System in place that monitors subcontractors.
Evidence that each operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Annually, AMA will make available a summary of the waiver performance measure outcomes for review by waiver participants, families, and other stakeholders.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify:	**Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

The Medicaid Agency is responsible for collecting data regarding the quality of services provided from various sources. Data is collected using quality indicators from each of the seven Program Design Focus areas of the Quality Framework. Also, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions. Annually, AMA will make available a summary of the waiver performance measure outcomes for review by waiver users, families, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The collected data is reported quarterly and annually to the Operating Agency (OA) and to Medicaid's LTC Division for evaluation and recommendations for program improvements. The Alabama Medicaid is the administering authority over the Elderly and Disabled Waiver Program; therefore, recommendations for improvements are evaluated for final determination to determine if there is a need for changes to the program.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months ***(Select one):***

No

Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

On October 1, 2017, the Alabama Medicaid Agency (AMA)implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's EVVM System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

Processes of the EVVM system:
1. When a service is authorized for a member, a schedule can be entered into the EVVM system.
2. The provider agency employee (worker) arrives at the member location to provide a service.
3. The worker checks into the system using the following:
The worker's mobile device to log the visit using the EVVM app (or the recipient phone will be utilized to dial into the Interactive Voice Response (IVR)
system as the authorized back-up method).
The worker enters their worker ID, selects the recipient and the service they are going to perform.
4. Using GPS technology, the location from which the service is rendered is validated.
5. The system verifies that the worker is appropriate to provide the prior authorized service for the member and advises the worker that he/she is checked in.
6. After the worker performs the service, the worker checks out using the same process and indicates specific tasks performed.
7. Claims will be available for the provider's review via the EVVM system website in real-time.
8. After the provider's review, the provider should confirm the claim.
9. Once confirmed, claims are automatically submitted for payment.

Services subject to EVV under the HHCS are Personal Care, Respite, Companion, Homemaker, and Supervisory Visits.

Payments to the Operating Agency (OA) for administrative services are adjusted to actual cost at the end of each waiver year. The OA submits documentation to Medicaid before the first day of the third month of the next quarter. The quarterly cost report includes all actual costs incurred by the OA for the previous quarter and includes costs incurred for the current year to date. Failure to submit the actual cost documentation can result in the AMA deferring payment until documentation has been received and reviewed. AMA will recover payments that exceed actual allowable cost.

AMA's post-payment financial audit program for the E & D Waiver is designed to ascertain that only reasonable and allowable expenses are included in the cost report received from the OA. Cost reports are due to AMA no later than 90 days after the fiscal year end.

AMA's Provider Audit Division performs the audit of the OA Cost Report. An audit of the cost reports is conducted annually. These audits are limited in scope. The auditor conducts a sampling process of the OA's expenditures. The sample includes, but is not limited to, provider contracts, cost allocation, previous audits, cash disbursements, general ledger accounts, cash receipts, verification of deposits, payroll records including employee time sheets, cancelled checks, vendor invoices or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditor's findings and opinion regarding compliance and internal control. After the sample is completed, the auditor will make adjustments to the cost report, if necessary. The OA's adjusted cost report is compared to Medicaid's paid file for final settlement. The samples are statistically valid with a 95% confidence level and a +/- 5% margin of error; both desk reviews and onsite reviews could be performed based on the Division's fiscal year obligations; Results are communicated to the OA via letter; The state could require a CAP if necessary, the CAP would include ongoing monitoring.

Providers of waiver services are not required to secure an independent audit of their financial statement although the OA reviews financial criteria based on what they require of their providers. The ICN is required to have its contracted independent certified public accountant submit directly to the Agency its annual audited financial statements prepared in accordance with generally accepted accounting principles and generally accepted auditing standards no later than one hundred-twenty (120) Calendar Days after the Contractor's Fiscal Year end, for the immediately preceding year. The Agency may request supplemental financial information be included with the Contractor's audited financial statements related to capital and surplus and other related information. A statement shall be included with the audit report delivered by the Contractor's accountant acknowledging that the Agency is an intended beneficiary of the audit report. The Contractor must provide to the Agency a periodic financial report containing information about the Contractor's capital and surplus and other related information as requested by the Agency.

Alabama's 1915b PCCM-E (ICN) receives a monthly capitated payment inclusive of HCBS Case Management and pays the case management providers based on the contract with AMA. The OA and AMA are audited externally by the Alabama Department of Public Examiners of Public Accounts. Annually, the state submits a SEFA (Statement of Expenditures of Federal Award) to the Examiners of Public Accounts. The waiver programs are shown in CFDA 93.778M.
Any inappropriate payments are recouped from the OA. The MMIS vendor reverses the claims and the FFP.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

      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. NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver]/DENOMINATOR [Number of claims paid]

      Data Source *(Select one):*
      Other
      If 'Other' is selected, specify:
      Claims data

Responsible Party for data collection/generation *(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. NUMERATOR [Number of participant records reviewed that show claims were coded correctly, and paid, only for services that were rendered]/DENOMINATOR [Number of participant records reviewed]

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: 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. NUMERATOR [Number of rates that remain consistent with the approved rate methodology throughout the five-year waiver] /DENOMINATOR [Number of rates]

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data

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

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

Data Aggregation and Analysis:

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

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

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

The Alabama Medicaid Agency (AMA) has contracted with a fiscal agent to maintain the payment records on services received and billed under the Elderly and Disabled (E&D) Waiver. The Operating Agency (OA) ensures that all services and corresponding payments are coded and documented properly. The OA ensures that only those services included on the plan of care are billed for the E&D Waiver participant.
On October 1, 2017, the AMA implemented an EVVM system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's Electronic Visit Verification and Monitoring System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and E&D Waiver eligibility before the claims are paid. The AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.

To ensure maximum reimbursement to services providers, the AMA is notified of any claims payment issues and will work with the OA and the fiscal intermediary to resolved the issues.

The AMA through the Decision Support System can generate adhoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method 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 Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by Alabama Department of Seniors Services. AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. AMA assumes the responsibility of: (1) Conducting joint trainings as needed with Medicaid enrolled direct service providers (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver Program; (3) Conducting quarterly meetings to disseminate policies, rules and regulations regarding the Home and Community-Based Waiver Program and;(4) signing all qualified direct service providers contracts enrolled with ADSS to provide waiver services.

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

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).*

Rates for Elderly and Disabled (E & D) Waiver services are established by Alabama Medicaid Agency (AMA) and the operating Agency (OA). Prospective rates are based on audited historical costs with consideration given to the health care index, rates of neighboring states, surveys, and renegotiated contracts.

The OA determines rate reimbursement for waiver providers. The rate is formulated using historical information, comparable southeastern states' data, provider feedback and recipient feedback. Through the 1915j the rate determination method for self-directed services differs in that the self-directed services rates are based on a budget developed to effectively meet the care needs of the recipient. The counselor assists with managing the budget to prevent overspending or underutilization whereas the rates for provider-managed care are developed Rates for Elderly and Disabled Waiver services are established by Alabama Medicaid Agency and the operating Agency based on periodic evaluations and assessments to determine if the rates are consistent with efficiency, economy, and quality of care.

AMA pays private and public contractors the same rate. Rates for all services are reviewed annually and reexamined at any time. AMA also performs periodic evaluations and assessments to determine if the rates are consistent with efficiency, economy, and quality of care. Stakeholders, participants, and providers may submit information or request information regarding the rate methodology at any time. Also, AMA periodically survey providers to request their feedback on rates. Providers have an opportunity to request information about the rate methodology AMA solicits public comments on rate determination during the public comment periods. Reference section Main 6-1 for information regarding the public comment period for the waiver renewal application process.

The link to the provider fee schedule is : https://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx. The fee schedule contains rates for state plan services. It does not contain waiver rates for providers. The Operating Agency has their own rate schedules for which they pay their providers which is a consistent rate for each service across all geographic locations. Rates are reviewed and revised on an ongoing basis. The most recent rate increase was FY22. The OA develops rates and are sent to AMA for approval. AMA evaluates the rate in comparison to rates for similar services and access to providers. Once AMA approves the MMIS is updated and cannot be changed again without AMA approval.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Each waiver participant, once approved, is added to the AMA's Long Term Care File. This file holds approved dates of eligibility for waiver services. Payments made by AMA to providers are on a fee for service reimbursement basis. Each covered service is identified on a claim by a HCPC code. For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. Each service type is identified by procedure code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.

Providers billings flow directly from the providers to the AMA MMIS through the Fiscal Intermediary as follows:

All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to AMA's policy to ensure that recipient benefits are paid according to current policies.

If the submitted claims covers dates of service where part, or all of which were covered in a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing. Payment is based on the number of units of service reported on the claim for each procedure code.

Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report. All claims must be filed within twelve months from the date of service. AMA recovers payments that exceed actual allowable amount.

Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement

AMA's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of home and Community Based (HCBS) Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers based on contract agreement with AMA. The ICN provides additional Medical Case Management Services to individuals. The ICN is required to comply with existing 1915(c) requirements related to assuring health and safety of waiver participants. For each waiver service, a HCPC code is determined with a rate assigned to each code. The AMA Management Information System (MMIS) pays the claim based upon the state's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations.
AMA's 1915b PCCM-E (ICN) receives a monthly capitated payment inclusive of home and Community Based (HCBS) Case Management. The ICN reviews the Case Management claims and reimburses the HCBS Case Management providers based on contract agreement with AMA. AMA identifies ICN enrollees via the MMIS on a monthly basis. This amount may be adjusted by AMA based on additions or deletions of participants.

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:*

On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's EVVM System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management. The EVVM also allows the care plan to be loaded into the system. Once the care plan is loaded the system sends an authorization to the service provider. Based upon the authorization a schedule is built for the home attendant. After the home attendant checks in and out of the EVVM system it automatically timestamp and record the visit.

AMA MMIS validates the visit by matching it to the care plan & authorization. If the visit is valid the system prepares a claim to be exported to AMA.
The EVV system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the HCPC code is valid for the diagnosis; the recipient is eligible, and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day.

For non-EVV claims, the MMIS has built in edits that will deny payment on a claim if the person is not Medicaid eligible or enrolled in a waiver. Additionally, the edits manage any utilization limits per service or age restricted service. Prior to billing the MMIS the OA matches services to approved care plan.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to AMA policy. The system then prices the claim using the state's determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced, and checks are written, if applicable.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

The Operating Agency conducts post payment reviews and ensures only claims for services rendered are paid. Inappropriate claims are recouped from the Operating Agency. They will be identified as a credit to FFP due when the MMIS sends data to AMA Finance and its processed.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with*

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

Yes. State or local government providers receive payment for waiver services. *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Alabama's Area Agencies on Aging (local government) provides Home and Community-based Services (HCBS) Case Management services for the E&D Waiver. Alabama's 1915b PCCM-E (ICN) receives a monthly capitated payment inclusive of HCBS Case Management and pays the Case Management providers based on contract agreement with AMA.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any

supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Alabama's 1915b PCCM-E (ICN) receives a monthly capitated payment inclusive of HCBS Case Management and pays the Case Management providers based on contract agreement with AMA.

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.

Alabama Department of Senior Services

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 §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The source of non-federal funds for the E&D Waiver is the general fund appropriations to ADSS. These funds are 106, general fund; 349, other funds such as federal, intergovernmental transfers, drug rebates, and other small amounts; 564, Health Care Trust Funds for provider taxes; and 1047, tobacco revenue. These funds are for the sole use of Medicaid once the appropriation is made by the Legislature. The Alabama Legislature does not line item budget any revenue or expenditures for Medicaid. In other words, no revenue comes to Medicaid earmarked for certain expenditures. It is up to Medicaid to determine how a voucher is coded and thus charged. If Medicaid has any balance in fund 106 at the end of the year, it does not revert back to the State general fund.
Partial funding for new services listed in the major changes section will come from the Agency's approved spending plan for ARP 9817 funds.

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	7211.27	11000.00	18211.27	57000.00	3100.00	60100.00	41888.73
2	7357.86	11500.00	18857.86	59850.00	3200.00	63050.00	44192.14
3	8319.71	12000.00	20319.71	62842.00	3300.00	66142.00	45822.29
4	9888.99	12500.00	22388.99	65984.00	3400.00	69384.00	46995.01
5	9953.43	13000.00	22953.43	69283.00	3500.00	72783.00	49829.57

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	15000	15000
Year 2	15000	15000
Year 3	15000	15000
Year 4	15000	15000
Year 5	15000	15000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of stay is derived by dividing the total number of days in a waiver year by the total number of clients served. ALOS shows consistent over the waiver period due to fluctuating utilization during the PHE.

ALOS have varied significantly during Covid starting in March 2020. We used conservative estimates based on recent actual experience. Sources include: Historical agency data, PHE enrollment, MOE requirements, previous 372 data for FY18-22.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is the projection of spending for each waiver participant for waiver years 1-5. It is based on the trending of data on the most recent CMS-372 Report, Waiver #0068, for the approved Waiver Year 1 and Waiver Year 2 of the current waiver, incorporating a 10% inflation in service. Then the state considered the grand total cost of waiver services for each year of the renewal application and divided the projected total by the number of unduplicated participants.
The State uses historical cost and utilization data for this waiver and like Nursing Facility Level of Care Waivers in the State to develop estimates. Sources include: Historical agency data, PHE enrollment, MOE requirements, previous 372 data for FY18-22. Due to the scope of service provision encompassing Campion Services, an unchanged level projection was provided by completing a look back of previous WYs. Companion services are limited in scope compared to the population's needs which limits its utilization. When a recipient's needs are greater than the provision of services, then the recipient is moved to a greater service to meet the need. Due to decreasing health conditions of the population related to COVID epidemic and considering population health, Skilled Respite may be the service that will be increasing during this Waiver period.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is the projection of state plan spending for each waiver participant for waiver years 1-5. It is based on the trending of data on the most recent CMS-372 Report, Waiver #0068, for the approved Waiver Year 1 and Waiver Year 2 of the current waiver incorporating a $500 cost increase for each waiver year. Due to the Public Health Emergency (PHE) encompassing the last three years of the current waiver period, the use of historical waiver service may be atypical as some services which were frequently used prior to the PHE were used less frequent due to limited face to face contact and visits to the home.
The State uses historical cost and utilization data to develop estimates. Sources include: Historical agency data, PHE enrollment, MOE requirements, previous 372 data for FY 18-22.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is the projection of nursing facility care for Waiver years 1-5 [average nursing home per diem (currently $230) x Average length of stay of (currently 300 days) – average patient liability (currently $12k) and taking into consideration data trends from the most recent CMS-372 Report, Waiver #0068, for Waiver Year 1 and Waiver Year 2 of the approved waiver. A 5% increase was applied to each waiver year 2, 3, 4, and 5 for inflation in the healthcare delivery system to include, but not limited to overhead and increase cost of health care workers.
Due to the PHE and the Nursing Facility average daily census fluctuations, conservative estimates were used as historical data since 2020 varies significantly. Sources include: Historical agency data, PHE enrollment, MOE requirements, previous 372 data for FY18-22.

iv. ***Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is the projection of state plan services for a nursing facility resident for Waiver years 1-5. It is based on the trending of data on the most recent CMS-372 Report, Waiver #0068, for the approved Waiver Year 1 and Waiver Year 2 and taking into consideration the cost for inflation in healthcare and in healthcare providers.
The State uses historical cost and utilization data to develop estimates.
Sources include: Historical agency data, PHE enrollment, MOE requirements, previous 372 data for FY18-22.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health With Transportation	
Case Management	
Homemaker	
Personal Care	
Skilled Respite	
Adult Companion Service	
Adult Day Health Without Transportation	
Assistive Technology and DME	
Home Delivered Meals	
Home Modification	
Medical Supplies	
Personal Emergency Response System (PERS) Installation	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly	
Pest Control Services	
Skilled Nursing	

Waiver Services	
Supervisory Visit	
Unskilled Respite	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Adult Day Health With Transportation Total:							1222320.00
Adult Day Health With Transportation		Per Day	100	240.00	50.93	1222320.00	
Case Management Total:							3366000.00
Case Management		Per month	11000	1.00	306.00	3366000.00	
Homemaker Total:							22705213.44
Homemaker		Per 15 min	6812	768.00	4.34	22705213.44	
Personal Care Total:							25459200.00
Personal Care		Per 15 min	6000	960.00	4.42	25459200.00	
Skilled Respite Total:							4413696.00
Skilled Respite		Per 15 min	350	1536.00	8.21	4413696.00	
Adult Companion Service Total:							2118144.00
Adult Companion Service		Per 15 min	350	1536.00	3.94	2118144.00	
Adult Day Health Without Transportation Total:							245580.00
Adult Day Health Without Transportation		Per day	25	240.00	40.93	245580.00	
Assistive Technology							2000000.00
GRAND TOTAL:							108169087.44
Total: Services included in capitation:							19367904.00
Total: Services not included in capitation:							88801183.44
Total Estimated Unduplicated Participants:							15000
Factor D (Divide total by number of participants):							7211.27
Services included in capitation:							1291.00
Services not included in capitation:							5920.08
Average Length of Stay on the Waiver:							295

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and DME Total:							
Assistive Technology and DME		Per item	1000	1.00	2000.00	2000000.00	
Home Delivered Meals Total:							19801586.00
Home Delivered Meals		14/wk	4900	127.00	31.82	19801586.00	
Home Modification Total:							10000000.00
Home Modification		per year	2000	1.00	5000.00	10000000.00	
Medical Supplies Total:							4800000.00
Medical Supplies		per year	4000	1.00	1200.00	4800000.00	
Personal Emergency Response System (PERS) Installation Total:							1196000.00
Personal Emergency Response System (PERS) Installation		Per item	4000	1.00	299.00	1196000.00	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly Total:							2160000.00
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly		Per month	4000	12.00	45.00	2160000.00	
Pest Control Services Total:							50000.00
Pest Control Services		Per incidence	500	1.00	100.00	50000.00	
Skilled Nursing Total:							710400.00
Skilled Nursing		Per hour	20	960.00	37.00	710400.00	
Supervisory Visit Total:							1100004.00
Supervisory Visit		Per 15 min	5914	6.00	31.00	1100004.00	
Unskilled Respite Total:							6820944.00
Unskilled Respite		Per 15 min	1286	1200.00	4.42	6820944.00	

GRAND TOTAL:	108169087.44
Total: Services included in capitation:	19367904.00
Total: Services not included in capitation:	88801183.44
Total Estimated Unduplicated Participants:	15000
Factor D (Divide total by number of participants):	7211.27
Services included in capitation:	1291.00
Services not included in capitation:	5920.08
Average Length of Stay on the Waiver:	295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Adult Day Health With Transportation Total:							1344552.00
Adult Day Health With Transportation		Per day	110	240.00	50.93	1344552.00	
Case Management Total:							3519000.00
Case Management		Per month	11500	1.00	306.00	3519000.00	
Homemaker Total:							22931865.60
Homemaker		Per 15 min	6880	768.00	4.34	22931865.60	
Personal Care Total:							25713792.00
Personal Care		Per 15 min	6060	960.00	4.42	25713792.00	
Skilled Respite Total:							4855065.60
Skilled Respite		Per 15 min	385	1536.00	8.21	4855065.60	
Adult Companion Service Total:							2118144.00
Adult Companion Service		Per 15 min	350	1536.00	3.94	2118144.00	
Adult Day Health Without Transportation Total:							275049.60
Adult Day Health Without Transportation		Per day	28	240.00	40.93	275049.60	
Assistive Technology and DME Total:							2000000.00
Assistive Technology and DME		Per item	1000	1.00	2000.00	2000000.00	
Home Delivered Meals							19999601.86
GRAND TOTAL:							110367970.66
Total: Services included in capitation:							19538205.60
Total: Services not included in capitation:							90829765.06
Total Estimated Unduplicated Participants:							15000
Factor D (Divide total by number of participants):							7357.86
Services included in capitation:							1302.55
Services not included in capitation:							6055.32
Average Length of Stay on the Waiver:							295

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Home Delivered Meals		14/wk	4949	127.00	31.82	19999601.86	
Home Modification Total:							10000000.00
Home Modification		Per year	2000	1.00	5000.00	10000000.00	
Medical Supplies Total:							4800000.00
Medical Supplies		Per year	4000	1.00	1200.00	4800000.00	
Personal Emergency Response System (PERS) Installation Total:							1196000.00
Personal Emergency Response System (PERS) Installation		Per item	4000	1.00	299.00	1196000.00	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly Total:							2160000.00
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly		Per month	4000	12.00	45.00	2160000.00	
Pest Control Services Total:							55000.00
Pest Control Services		Per incidence	550	1.00	100.00	55000.00	
Skilled Nursing Total:							781440.00
Skilled Nursing		Per hour	22	960.00	37.00	781440.00	
Supervisory Visit Total:							1118604.00
Supervisory Visit		Per 15 min	6014	6.00	31.00	1118604.00	
Unskilled Respite Total:							7499856.00
Unskilled Respite		Per 15 min	1414	1200.00	4.42	7499856.00	
GRAND TOTAL:							110367970.66
Total: Services included in capitation:							19538205.60
Total: Services not included in capitation:							90829765.06
Total Estimated Unduplicated Participants:							15000
Factor D (Divide total by number of participants):							7357.86
Services included in capitation:							1302.55
Services not included in capitation:							6055.32
Average Length of Stay on the Waiver:							295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Adult Day Health With Transportation Total:							1466784.00
Adult Day Health With Transportation		Per Day	120	240.00	50.93	1466784.00	
Case Management Total:							3672000.00
Case Management		Per month	12000	1.00	306.00	3672000.00	
Homemaker Total:							27244922.88
Homemaker		Per 15 min	8174	768.00	4.34	27244922.88	
Personal Care Total:							30551040.00
Personal Care		Per 15 min	7200	960.00	4.42	30551040.00	
Skilled Respite Total:							5296435.20
Skilled Respite		Per 15 min	420	1536.00	8.21	5296435.20	
Adult Companion Service Total:							2118144.00
Adult Companion Service		Per 15 min	350	1536.00	3.94	2118144.00	
Adult Day Health Without Transportation Total:							294696.00
Adult Day Health Without Transportation		Per Day	30	240.00	40.93	294696.00	
Assistive Technology and DME Total:							2000000.00
Assistive Technology and DME		Per item	1000	1.00	2000.00	2000000.00	
Home Delivered Meals Total:							23761903.20
Home Delivered Meals		14/wk	5880	127.00	31.82	23761903.20	
Home Modification Total:							10000000.00

GRAND TOTAL:	124795681.28
Total: Services included in capitation:	19698684.00
Total: Services not included in capitation:	105096997.28
Total Estimated Unduplicated Participants:	15000
Factor D (Divide total by number of participants):	8319.71
Services included in capitation:	1313.00
Services not included in capitation:	7006.47
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification		Per year	2000	1.00	5000.00	10000000.00	
Medical Supplies Total:							4800000.00
Medical Supplies		Per year	4000	1.00	1200.00	4800000.00	
Personal Emergency Response System (PERS) Installation Total:							1196000.00
Personal Emergency Response System (PERS) Installation		Per item	4000	1.00	299.00	1196000.00	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly Total:							2160000.00
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly		Per month	4000	12.00	45.00	2160000.00	
Pest Control Services Total:							60000.00
Pest Control Services		Per incidence	600	1.00	100.00	60000.00	
Skilled Nursing Total:							852480.00
Skilled Nursing		Per hour	24	960.00	37.00	852480.00	
Supervisory Visit Total:							1137204.00
Supervisory Visit		Per 15 min	6114	6.00	31.00	1137204.00	
Unskilled Respite Total:							8184072.00
Unskilled Respite		Per 15 min	1543	1200.00	4.42	8184072.00	
GRAND TOTAL:							124795681.28
Total: Services included in capitation:							19698684.00
Total: Services not included in capitation:							105096997.28
Total Estimated Unduplicated Participants:							15000
Factor D (Divide total by number of participants):							8319.71
Services included in capitation:							1313.00
Services not included in capitation:							7006.47
Average Length of Stay on the Waiver:							295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Adult Day Health With Transportation Total:							1711248.00
Adult Day Health With Transportation		Per day	140	240.00	50.93	1711248.00	
Case Management Total:							3780630.00
Case Management		Per month	12355	1.00	306.00	3780630.00	
Homemaker Total:							31784632.32
Homemaker		Per 15 min	9536	768.00	4.34	31784632.32	
Personal Care Total:							42771456.00
Personal Care		Per 15 min	10080	960.00	4.42	42771456.00	
Skilled Respite Total:							6179174.40
Skilled Respite		Per 15 min	490	1536.00	8.21	6179174.40	
Adult Companion Service Total:							2118144.00
Adult Companion Service		Per 15 min	350	1536.00	3.94	2118144.00	
Adult Day Health Without Transportation Total:							343812.00
Adult Day Health Without Transportation		Per day	35	240.00	40.93	343812.00	
Assistive Technology and DME Total:							2000000.00
Assistive Technology and DME		Per item	1000	1.00	2000.00	2000000.00	
Home Delivered Meals Total:							27722220.40
Home Delivered Meals		14/wk	6860	127.00	31.82	27722220.40	
Home Modification Total:							10000000.00
Home Modification		Per year	2000	1.00	5000.00	10000000.00	
Medical Supplies Total:							4800000.00

GRAND TOTAL:	**148334881.12**
Total: Services included in capitation:	19667052.00
Total: Services not included in capitation:	128667829.12
Total Estimated Unduplicated Participants:	**15000**
Factor D (Divide total by number of participants):	**9888.99**
Services included in capitation:	1311.00
Services not included in capitation:	8577.86
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Supplies		Per year	4000	1.00	1200.00	4800000.00	
Personal Emergency Response System (PERS) Installation Total:							1196000.00
Personal Emergency Response System (PERS) Installation		Per item	4000	1.00	299.00	1196000.00	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly Total:							2160000.00
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly		Per month	4000	12.00	45.00	2160000.00	
Pest Control Services Total:							70000.00
Pest Control Services		Per incidence	700	1.00	100.00	70000.00	
Skilled Nursing Total:							994560.00
Skilled Nursing		Per hour	28	960.00	37.00	994560.00	
Supervisory Visit Total:							1155804.00
Supervisory Visit		Per 15 min	6214	6.00	31.00	1155804.00	
Unskilled Respite Total:							9547200.00
Unskilled Respite		Per 15 min	1800	1200.00	4.42	9547200.00	
GRAND TOTAL:							148334881.12
Total: Services included in capitation:							19667052.00
Total: Services not included in capitation:							128667829.12
Total Estimated Unduplicated Participants:							15000
Factor D (Divide total by number of participants):							9888.99
Services included in capitation:							1311.00
Services not included in capitation:							8577.86
Average Length of Stay on the Waiver:							295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Adult Day Health With Transportation Total:							1833480.00
Adult Day Health With Transportation		Per day	150	240.00	50.93	1833480.00	
Case Management Total:							3780630.00
Case Management		Per month	12355	1.00	306.00	3780630.00	
Homemaker Total:							34057820.16
Homemaker		Per 15 min	10218	768.00	4.34	34057820.16	
Personal Care Total:							38188800.00
Personal Care		Per 15 min	9000	960.00	4.42	38188800.00	
Skilled Respite Total:							6620544.00
Skilled Respite		Per 15 min	525	1536.00	8.21	6620544.00	
Adult Companion Service Total:							2118144.00
Adult Companion Service		Per 15 min	350	1536.00	3.94	2118144.00	
Adult Day Health Without Transportation Total:							373281.60
Adult Day Health Without Transportation		Per day	38	240.00	40.93	373281.60	
Assistive Technology and DME Total:							2000000.00
Assistive Technology and DME		Per item	1000	1.00	2000.00	2000000.00	
Home Delivered Meals Total:							29702379.00
Home Delivered Meals		14/wk	7350	127.00	31.82	29702379.00	
Home Modification Total:							10000000.00
Home Modification		Per year	2000	1.00	5000.00	10000000.00	
Medical Supplies Total:							4800000.00
Medical Supplies		Per year	4000	1.00	1200.00	4800000.00	
Personal Emergency Response System							1196000.00

GRAND TOTAL:	**149301458.76**
Total: Services included in capitation:	19807884.00
Total: Services not included in capitation:	129493574.76
Total Estimated Unduplicated Participants:	**15000**
Factor D (Divide total by number of participants):	**9953.43**
Services included in capitation:	1321.00
Services not included in capitation:	8632.90
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(PERS) Installation Total:							
Personal Emergency Response System (PERS) Installation		Per item	4000	1.00	299.00	1196000.00	
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly Total:							2160000.00
Personal Emergency Response Systems (PERS)-Vendor Monitoring/Monthly		Per month	4000	12.00	45.00	2160000.00	
Pest Control Services Total:							70000.00
Pest Control Services		Per incidence	700	1.00	100.00	70000.00	
Skilled Nursing Total:							994560.00
Skilled Nursing		Per hour	28	960.00	37.00	994560.00	
Supervisory Visit Total:							1174404.00
Supervisory Visit		Per 15 min	6314	6.00	31.00	1174404.00	
Unskilled Respite Total:							10231416.00
Unskilled Respite		Per 15 min	1929	1200.00	4.42	10231416.00	

GRAND TOTAL:	**149301458.76**
Total: Services included in capitation:	19807884.00
Total: Services not included in capitation:	129493574.76
Total Estimated Unduplicated Participants:	**15000**
Factor D (Divide total by number of participants):	**9953.43**
Services included in capitation:	1321.00
Services not included in capitation:	8632.90
Average Length of Stay on the Waiver:	295