

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

This renewal includes:
Add Pest Control Service

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*):

Technology Assisted Waiver-TA Waiver

- C. **Type of Request: renewal**

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

- 3 years 5 years

Original Base Waiver Number: AL.0407

Draft ID: AL.020.04.00

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

Regular Waiver

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

02/23/21

1. Request Information (2 of 3)

- F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals

who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §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:

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 Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §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. Statewidness. Indicate whether the state requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):

- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewidness 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 statewidness 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §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:

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

The Poarch Band of the Creek Indians is included in communication regarding new programs or changes to existing programs. They have the ability to comment and provide feedback on these programs at any time. The State's normal procedure, per Federal regulation, is to send a letter to the Tribal governments, giving them an opportunity to respond to changes or additions to the Home and Community-Based Waiver Programs. This procedure was followed. To date, no response has been received.

30 Day Comment Period opened 11/9/2020

The state posted the entire TA Waiver document for public comment for 30 days. There were two forms of notice posted. They include a post to the Alabama Medicaid Agency Web site and hard copy availability at the 11 Medicaid District Offices.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Wettingfeld

First Name:

Ginger

Title:

Director, LTC Healthcare Reform

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Ave.

Address 2:

P.O. Box 5624

City:

Montgomery

State:

Alabama

Zip:

36103-5624

Phone:

(334) 242-5018 Ext: TTY

Fax:

(334) 353-3642

E-mail:

ginger.wettingfeld@medicaid.alabama.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Alabama

Zip:

Phone:

Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

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

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

in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Alabama

Zip:

Phone: Ext: TTY

Fax:

E-mail:
Attachments

Attachment #1: Transition Plan

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

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

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

Specify the transition plan for the waiver:

No transition plan required for changes in this renewal

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 Technology-Assisted (TA) waiver provides services to adults with complex skilled medical conditions who would otherwise require nursing facility level of care. These services are comprised of the following:

- Private Duty Nursing
- Personal Care/Attendant Services
 - Medical Supplies
- Assistive Technology
 - Personal Choice
 - Pest Control Service

TA Waiver services are delivered in the private dwellings of the waiver participants. Annually, the TA Waiver Program Manager at the Alabama Medicaid Agency (AMA) assesses 100% of the clients for health and safety of their home environment. The TA Waiver Program Manager makes these assessments in each individual client's home. An onsite review of individuals' residential settings was completed by the Alabama Medicaid Agency (AMA) Program Manager for the TA waiver, over the course of the period from January – December 2014. As of February, 2015, this review confirmed that TA waiver participants exclusively reside in private home dwellings located in the community. This waiver does not provide any services in congregate living facilities, institutional settings or adjacent to or on the grounds of institutions. The State therefore presumes that these dwellings meet the characteristics of home and community-based residential settings. Based on this assumption, the State concludes that there is no need for a transition plan with regard to TA participants' residential settings.

The State shall conduct ongoing monitoring to ensure that participants continue to live and receive services in their own private residences by ADSS (Alabama Department of Senior Services) Case Managers notifying the AMA (Alabama Medicaid Agency) TA Waiver Program Manager of any change during their monthly face-to-face mandatory visits. Changes that include any new services shall be noted on the participant's POC (Plan of Care) and the AMA TA Waiver Program Manager shall be notified. Further, the AMA TA Waiver Program Manager will verify the private residency during the annual visit of 100% of TA Waiver participants.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

There were no comments received on this waiver-specific transition plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

Long Term Care Health Care Reform

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

The Alabama Department of Senior Services (ADSS) performs limited operational functions for the AMA. ADSS provides Targeted Case Management to include participant enrollment, level of care evaluations, monthly and as needed home visits to perform assessment of the individual participant by registered nurses, and review of plans of care. Any needs or changes identified by the Targeted Case Manager and the individual participant are updated in their care plan.

ADSS also serves as the provider for targeted and transitional case management activities for Personal Choices. TA Waiver participants will be given the opportunity to self-direct Personal Care/Attendant Services as provided within the 1915(j) State plan 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:

- 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 Alabama Medicaid Agency (AMA) is responsible for assessing the performance of the Alabama Department of Senior Services in the performance of targeted case management, transitional case management, and Personal Choice activities. The work of the AMA is monitored by operating the waiver in accordance with the approved waiver document. ADSS and AMA have a relationship that is open to feedback both ways.

CMS monitors the AMA through the compliance review process which documents the quality assurance and quality improvement activities employed by the AMA.

Appendix A: Waiver Administration and Operation

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

The AMA conducts reviews of TA Waiver participant's records, and case management documentation on an annual basis. ADSS and AMA will follow up on any concerns/feedback/questions that are received on the TA Waiver Participant Satisfaction Surveys. This will ensure participant satisfaction as well as ensure that waiver operational and administrative functions are followed in accordance with State and Federal requirements.

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	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒

Function	Medicaid Agency	Contracted Entity
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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:

Number and Percent of data reports specified in: agreements and policies and procedures, with the Medicaid Agency, that were submitted on time and in the correct format.

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):
--	---	---

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">ADSS</div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Technology Dependent	21		<input checked="" type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The target group for the TA Waiver is individuals who are 21 years of age or older with complex medical conditions who meet the nursing facility level of care. These individuals have a medical history of being ventilator-dependent or have a tracheostomy.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

The cost limit is based on the annual cost of nursing home care for this particular population. The cost of nursing home care for ventilator dependent individuals is significantly higher than nursing home care for non-ventilator dependent individuals. It is adjusted when the annual cost of nursing homes change. It is applied uniformly, unless there is an emergency.

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

Participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and with the support of Home and Community-Based Waiver Services will not be enrolled in the waiver. Based upon orders received from the participant's attending physician, the Alabama Department of Senior Services (ADSS) will determine if the cost of the waiver services necessary to ensure that the participant's health and safety will not exceed 100% of the cost for the nursing facility level of care.

If the ADSS Targeted Case Manager determines that an applicant's need is more extensive than the waiver services are able to support, the ADSS Targeted Case Manager will inform the applicant that their health and safety cannot be assured in the community. The plan may be re-submitted in the future if the participant's needs have decreased sufficiently so that the State can assure the health and safety of the individual and the cost to provide services are within the cost limit established by the State. In the event that the applicant or participant is denied enrollment or continued enrollment the applicant will receive a denial letter from Medicaid which outlines their rights to a Fair Hearing in accordance with Medicaid program rules.

The state has contracted with ADSS to provide targeted case managers to complete a comprehensive assessment to identify all of the services that the individual needs. The targeted case manager looks at the services and providers available and then a plan of care is created. The targeted case manager determines that the services needed are less than 100% of the cost of nursing home placement.

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:

In the event that the participant's physician, ADSS and AMA determine that the participant has an extended need for a higher level of care than can be provided by the TA Waiver, the individual's plan of care will be revised and the participant will be transitioned to a hospital or nursing facility based upon the orders of the participant's attending physician. The primary physician will notify the participant and the case manager of the need to transition the participant from the waiver into an institution. To date, this situation has not occurred with any TA Waiver participant.

Participants can remain in the community as long as the TA Waiver meets their needs. However, if the participant's primary physician observes a significant decline in the participant's health, whereby more care is needed than the waiver can provide; then the primary physician will notify the participant and the case manager of the need for the participant to be transferred to a nursing facility or hospital.

For this particular group of participants who have a tracheostomy or are ventilator dependent, the TA Waiver provides more services specific to their needs. If there is a decline in the participant's condition, then hospitalization or nursing home placement is the most prudent choice. A participant can be considered for a different waiver if they no longer have a tracheostomy or no longer require the use of a ventilator. They would still have to meet the requirements for the waiver in which they plan to move.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	80
Year 2	80
Year 3	80
Year 4	80
Year 5	80

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- Not applicable. The state does not reserve capacity.
- The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes
Individuals who transfer from nursing facilities back into the community and from waiver-to-waiver.

Appendix B: Participant Access and Eligibility

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

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

Individuals who transfer from nursing facilities back into the community and from waiver-to-waiver.

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

The Agency has estimated that ten slots would be the amount needed to place in reserve capacity for individuals transitioning from the nursing facility and from waiver-to-waiver transfers.

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

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

Appendix B: Participant Access and Eligibility

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

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

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

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

local/regional non-state entities:

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

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

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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:

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

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

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

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

- The amount is determined using the following formula:

Specify:

The State is using post-eligibility rules for the period between January 1st 2014 and December 31st 2018 as per section 2404 of the ACA

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 maintenance needs allowance is equal to the individual's total income which includes income that is placed in a Miller Trust.

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

- Not Applicable**

- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §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 1st 2014 through December 31 2018 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

Specify the amount of the allowance (select one):

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

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

The amount is determined using the following formula:

Specify:

The state is using post-eligibility rules for the period January 1st 2014 through December 31 2018 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the 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:

- Other

Specify:

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

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

Select one:

- Allowance is the same
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

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

Other

Specify:

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

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

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

The Level of Care Criteria is as follows:

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

The Admission Criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specify the qualifications:

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

The ADSS Targeted Case Managers will re-evaluate each waiver participant's need for waiver services every 12 months. Participants medical records are reviewed, at a minimum, within 30 days of the expiration of the participants waiver eligibility period. The AMA TA Waiver Coordinator maintains a record of each waiver participants re-evaluation date in a Tickler File and will work closely with ADSS to ensure a timely re-evaluations. The Tickler File system will prompt the AMA TA Waiver Coordinator when re-determinations are due.

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:

Documentation (hard copy and/or electronic) of evaluations and re-evaluations are maintained in the following locations:
 The Alabama Medicaid Agency
 The Alabama Department of Senior Services
 The Direct Service Providers Office
 The Case Managers Office Files

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 completed assessments for determining level of care

submitted to the AAA office within 60 days of initial contact with the applicant

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of eligibility re-evaluations begun at least 30 days prior to the annual redetermination date.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 Level of Care determination forms that were completed as required by the Medicaid agency

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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

The AMA will work closely with the ADSS Targeted Case Manager to ensure that waiver participants are actively involved in decision-making related to the provision of waiver services and if waiver participants are encouraged to provide feedback to improve the program. The ADSS Targeted Case Manager is responsible for contacting the ADSS director about any concerns related to TA Waiver recipients. The ADSS director will notify AMA's TA waiver coordinator, if needed, to resolve any issues. In addition, the AMA TA Waiver Coordinator will review the complaints and grievance logs to ensure that the target dates of resolution are being met. If home visits are conducted the AMA TA Waiver Coordinator and ADSS Targeted Case Managers are responsible for conducting interviews with the TA Waiver participants to determine their satisfaction with the services they receive and the providers rendering their services.

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

The Freedom of Choice Forms are maintained in the participants records for a minimum of five years and are located at the following locations:

The Alabama Medicaid Agency
The Alabama Department of Senior Services

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Personal Care/Attendant Services		
Other Service	Assistive Technology		

Service Type	Service		
Other Service	Medical Supplies		
Other Service	Pest Control Service		
Other Service	Private Duty Nursing		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care/Attendant Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Personal Care/Attendant Services: PC/AS provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintain continence, medication management 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 provide with ADLs or essential to the health and welfare of the participant rather than the participant’s family.

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

This service will be provided to individuals with disabilities inside and outside of their home. It may enable waiver participants to enter or to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.

The unit of service will be in 15 minute increments, of direct PC/AS Service provided either in the participant’s residence or another setting outside of the home. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form or Service Provider contract.

The amount of time authorized does not include transportation time to and from the participant’s residence or place of employment or the Personal Care/Attendant Service worker’s break or mealtime.

The number of units and service provided to each participant is dependent upon the individual participant’s needs as set forth in the participant’s Plan of Care established by the case manager, if case management is elected by the participant, and subject to approval by the Alabama Medicaid Agency (AMA). Medicaid will not reimburse for activities performed which are not within the scope of services. If this service is being used for employment, the AMA will have a signed agreement with the employer stating that it is acceptable to have a PC/AS Worker on the job site.

Under this 1915c, relatives can be hired as providers of services if they are employed by an approved provider. Under the state's 1915j, a TA Waiver recipient can choose the individual that will provide their care. Under the 1915j, a worker can be a relative, legal guardian, or legally responsible person.

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/Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care/Attendant Services

Provider Category:

Agency

Provider Type:

Home Health/Home Care Agency

Provider Qualifications

License *(specify):*

Business

Certificate *(specify):*

Certificate of Need (CON)if the provider is not a Home Health Agency

Other Standard *(specify):*

Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Senior Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Assistive Technology: Assistive technology includes devices, equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities as specified in the Plan of Care. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include acquisition, selection, design, fitting, customizing, adaption, application, etc. Items reimbursed with waiver funds exclude items which are not of direct medical benefit to the recipient. Receipt of this service to prevent institutionalization will be documented in the medical record. All items must meet applicable standards of manufacturer, design and installation. Repairs and maintenance of assistive technology devices are included in this service.

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

The assistive technology item must be ordered by a physician, documented on the Plan of Care and must be prior authorized and approved by the Alabama Medicaid Agencies or its designee.

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

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

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

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

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	Assistive Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

State of Alabama business license

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Medical Supplies and Appliances: Medical supplies and appliances includes devices, controls or appliances specified in the Plan of Care, not presently covered under the State Plan, which enables the individual to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Waiver medical supplies and appliances do not include over-the-counter personal items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc.

Items reimbursed with waiver funds will be an addition to any medical supplies furnished under the State Plan and excludes those items which are not of direct medical or remedial benefit to the individual.

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

All waiver medical supplies and appliances must be prescribed by a physician and be specified in the Plan of Care.

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	Durable Medical Equipment Provider

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

State of Alabama business license

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

AMA-TA Waiver Coordinator

Frequency of Verification:

Initially then Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control Service

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

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

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

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

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed and Certified Pest Control Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Service

Provider Category:

Agency

Provider Type:

Licensed and Certified Pest Control Company

Provider Qualifications

License (specify):

State of AL business License

Certificate (specify):

Code of Alabama, 1975, § 40-12-40

Other Standard (specify):

Possess licensure and certification approved through the Alabama Department of Agriculture and Industries.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Initially; then annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Private Duty Nursing: A service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing.

Private Duty Nursing under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver participant meets the criteria to receive the home health benefits, home health is utilized first and exhausted before Private Duty Nursing under the waiver is utilized.

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

Private Duty Nursing: The unit of service is one hour of direct Private Duty Nursing care provided in the participant's home or other location of service. The number of units authorized per visit is stipulated on the Plan of Care (POC) and Service Authorization form. The amount of time authorized does not include transportation time to and from the participants residence or other location of service or the Private Duty Nurses break or mealtime.

The number of units and services provided to each participant is dependent upon the individual participants need as indicated in the participants POC established by the participant, the attending physician, the family and the case manager and is subjected to approval by the AMA.

Private Duty Nursing Services are reimbursable for up to 12 hours per day per participant except as otherwise provided.

Additional hours may be authorized for a maximum of 90 days if any of the following apply and the documentation supports the need for the additional hours.

1. Immediately following hospital discharge when the qualified caregiver is being trained in care and procedures;
2. There is an acute episode that would otherwise require hospitalization, and the treating physician determines that non-institutional care is still safe for the participant;
3. An alternate qualified caregiver must be identified and trained;
4. The approved caregiver is ill or temporarily unable to provide care; or
5. The Alabama Medicaid Agency determines it is medically necessary upon review of submitted medical documentation.

Approval of hours in excess of 12 hours per day may be granted subject to review every 30 days.

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	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications**License (specify):**

State of Alabama Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Certificate (specify):

Other Standard (specify):

1. At least 2 years experience
2. Must submit to a program for testing, prevention, and control of tuberculosis, annually
3. Private Duty Nursing Services provided by an LPN requires supervision by a licensed RN

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

AMA-TA Waiver Coordinator

Frequency of Verification:

Annual Personnel Record Review

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:

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

Appendix C: Participant Services

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

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

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

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

All positions (registered nurses (RN), license practical nurses (LPN), personal care workers, case managers, office staff that require participant contact shall have a background investigation. The scope of the background investigation is statewide. It is up to the direct service provider (DSP) to select a vendor to conduct the background investigation.

During the annual audit of the DSP's, the TA Waiver Coordinator shall check for background investigations on all employees who are in direct or indirect contact with any TA Waiver participant.

The TA Waiver Coordinator shall check for criminal history and/or background investigations for nurses providing Private duty nursing services. Additionally, the TA Waiver Coordinator shall check each nursing license to ensure that it is showing a current active date. However, since the Alabama Board of Nursing (ABN) has "discontinued issuing license and advanced practice approval cards", effective July 5, 2016; the TA Waiver Coordinator shall look for verification that the direct service provider contacted the ABN to "obtain primary source verification, either through an official Verification, the ABN Subscription Service, or the License Lookup system, all of which is available on the ABN website".

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; 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)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided 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 (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.*

Only as prescribed in Appendix E related to the 1915j

- 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.

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:

Enrollment of qualified providers is an ongoing process. Medicaid's fiscal agent, HPE, enrolls private duty nursing, home health and durable medical equipment providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of federal regulations, the Alabama Medicaid Agency Administrative Code and the Alabama Agency Provider manual. All willing and qualified providers are given an opportunity to enroll as TA waiver providers by requesting to become a provider of services for TA Waiver participants through the TA Waiver Coordinator. Once the TA Waiver Coordinator receives a request, it is sent to the Long Term Care Division for review. Once this request is satisfactorily reviewed, the request is sent to the Program Integrity Division for review. If there are no issues, the TA Waiver Coordinator is notified. The TA Waiver Coordinator notifies the qualified provider that they can provide services beginning on a specific date to TA Waiver participants. The process can take up to ten business days.

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 of providers, by provider type, that meet applicable licensure/certification at initial enrollment

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:
Number and percent of providers, by provider type, continuing to meet applicable licensure/certification

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

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>

Performance Measure:

Number and percent of providers, by type, who performed required background, registry, and provider exclusion database checks

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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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, by type, who met initial waiver provider qualifications

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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, by provider type, meeting state required provider training requirements

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

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

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

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">ADSS TCM provider</div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Alabama has reviewed the new HCB setting requirements for the TA waiver and has confirmed that this waiver is in compliance with the new regulations. A survey of individuals' residential settings was completed over the course of the period from October 2014 - February 2015 by the Targeted Case Management Agency (ADRS) during that time. ADRS case managers confirmed that waiver participants almost exclusively reside in private home dwellings located in the community.

Information regarding assessment tools, ongoing monitoring, and remediation activities are addressed in Alabama's Statewide Transition Plan.

The State will continue to assess all settings to ensure compliance with the settings rule.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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:

The case manager must meet the following educational requirements:
 Bachelors of Arts Degree or a Bachelor of Science Degree from an accredited college or university, preferably in a human services related field, or;
 Bachelor of Arts Degree or a Bachelor from an accredited School of Social Work, or;
 Bachelor of Science Degree in Nursing (BSN) from an accredited School of Nursing, licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with Code of Ala., 1975 34-21-21.

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

- Social Worker**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *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 Targeted Case Manager, the participant and/or a family of legal representative or other persons designated by the participant will all meet to develop the Person Centered Care Plan (PCCP). During the meeting all parties will discuss the needs of the participant, informal supports provided by family or other community resources, identify the gaps in supports, and are informed by the Targeted Case Manager of waiver services which may fill those gaps. The participant decides which personal representative will be involved in development of the Person Centered Care Plan. Development of the Person Centered Care Plan should include participation by the client, the individual's family/sponsor and Targeted Case Manager. This process will provide information for all individuals to make informed choices regarding available community services and support. Informal supports are crucial in supplementing the Person Centered Care Plan. Waiver services cannot be provided 24/7, therefore informal supports are used to ensure health and safety when waiver services are not in the home.

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

The PCCP development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources. All services needed by the participant will be included in the PCCP implemented by the Targeted Case Manager. Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The PCCP and service contracts will be updated to reflect any changes in service needs. Each case will be monitored monthly through contacts and at least one face-to-face visit monthly with the participant. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed.

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):

The person centered care plan (PCCP) is developed collaboratively with the participant, Targeted Case Manager, family or legal representative, and other persons designated by the participant. The PCCP is developed as a part of the initial assessment for all applicants for available waiver services and revised periodically as the needs of the participant changes. The Targeted Case Manager will schedule a meeting with all interested parties to secure information about the participant's needs, preferences, goals, other non-waiver services or community supports. The Targeted Case Manager completes a needs assessment to assist with the development of the PCCP. The participant and/or their family member or legal representative are informed of all of the services available through the waiver. Medical information obtained from the participant's physician is considered. The PCCP is then developed and is based upon the participant's functional capacity, limitations, health care needs, formal and informal supports from the family, caregiver(s) and community. PCCP's are individualized for each participant and seek to balance the participant's rights, values and preferences. Non-waiver services and community supports are a crucial part of the PCCP development. Waiver services are not permitted to be provided 24/7, therefore non-waiver services are needed to ensure an individual's health and safety. The amount, duration and frequency of all waiver services are documented in the PCCP to avoid duplication of services and to establish complete coordination of care. Services contained in the PCCP are those services the participant is willing to accept, for which the participant has a justifiable unmet need, and there is a qualified provider of direct services available to provide the designated services. The Targeted Case Manager completes a Service Authorization Form which is forwarded to the direct service provider to ensure services are provided in accordance with the PCCP. After the PCCP is completed and implemented, it will be evaluated for its effectiveness. The time frame for this evaluation will depend on numerous factors and will vary, but will always be completed at least annually corresponding with the participant's waiver eligibility dates. The Targeted Case Manager will review the PCCP with the participant, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are identified by the Targeted Case Manager, to be approved by the operating agency and updated. A copy of the PCCP remains in the participant's home. Services may be initiated or changed at any time within a contract period to accommodate a participant's changing needs. Any change in waiver services necessitates authorization from the operating agency and a revision of the PCCP. When a PCCP is revised, as warranted by changes in the participant's condition, the participant/and or their family member or legal representative must be issued a written notice at least ten days prior to any adverse actions that may result from the change.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Potential risks to participant's safety are addressed in the development of the Person Centered Care Plan (PCCP). Plans are individualized and should take into consideration participant's rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed and the PCCP is adjusted accordingly and evaluated for appropriateness. Also during the monthly visit, the Targeted Case Manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the POC. The Targeted Case Manager also documents, addresses and monitors any health and safety concerns. Additionally, DSP staff must visit the participant's home as ordered on the POC. DSPs are trained and expected to observe and report any concerns about a participant's health and welfare to the Targeted Case Manager and in writing to the supervisor at the DSP agency. Waiver applicant or participants are also informed of procedures necessary to file a formal complaint or grievance regarding availability, deliver or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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:

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.

When the Person Centered Care Plan (PCCP) is developed with the necessary waiver services, the participant is given a choice of qualified and willing providers of waiver services. The participant and/or their family or legal representative must complete a freedom of choice form to document that they were given a choice of qualified providers of waiver services. The entity responsible for monitoring the implementation of the PCCP and participant health and welfare is the Targeted Case Management staff during the face-to-face visit. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal supports included on the PCCP are delivering the amount and type of services that were committed. Participant's and/or responsible relatives shall be instructed to notify the Targeted Case Manager if services are not initiated as planned, or if the participant's condition changes. However, it is the responsibility of the Targeted Case Manager to promptly identify and implement needed changes in the PCCP. The OA also conducts random home visits to monitor PCCP implementation and assess the health and welfare of participants.

When a participant has been approved for TA waiver services and the PCCP implemented, or when changes are made to the POC, the Targeted Case Manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services included in the PCCP. The Targeted Case Manager must ensure that waiver services requested on the Service Authorization Form include only those services contained in the approved POC. 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. DSPs are trained and expected to observe and report any concerns in a participant's health and welfare to the Targeted Case Manager and in writing to the supervisor of the DSP agency. The supervisor of the DSP agency has a responsibility to contact Targeted Case Management staff immediately by telephone when services cannot be provided to an at risk participant. Annual desk reviews are performed by Medicaid and include Targeted Case Management personnel files, participant files, and visits to participants in their homes. Medicaid is informed by the Targeted Case Manager when there is a problem with a participant's service plan. Notification of critical situations is sent to Medicaid via "Critical Events/Incidents" forms and followed-up on until resolution. Less critical situations are sent to Medicaid via patient completed survey as well as discussion during home visits by the Targeted Case Manager. Data is evaluated for any type of trend in a participant's service plan. Negative trends could potentially be addressed by: updating the PCCP, reevaluating the DSP, or updating primary caregivers and their information. Rectifying problems with a participant's service plan 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 waiver participants who have person-centered service plans that are appropriate to their needs as indicated in the assessment

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<div style="border: 1px solid black; width: 80%; margin: 0 auto; height: 20px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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 participants whose service plans were developed by the type of personnel specified in the Waiver

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 service plan was modified due to changing needs over the total number of participants that had a change in need

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of service plans reviewed and revised before the participant's annual review date

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 survey respondents reporting the receipt of all services in the service plan

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 waiver participants whose record contains an appropriately completed and signed freedom of choice form that specifies choice was offered among providers

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 Medicaid Agency staff, the ADSS Targeted Case Manager and the Director of the Alabama Department of Senior Services meet regularly to discuss the TA Waiver general operations. If there are particular trends, changes to policy and procedures will ensue to accommodate the needs of the waiver population. As individual problems arise, decisions are made as a cooperative effort between the Targeted Case Manager, the ADSS Director, and the TA Waiver Coordinator. The population of this waiver is small and unique and each problem can be addressed individually to a satisfactory outcome.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="ADSS TCM provider."/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

If the participant chooses to access the 1915(j) Personal Choices Program, they will be offered the opportunity to direct and manage their own services to the extent they are able. If they are unable to manage their own services, they may appoint a representative to act on their behalf. The following processes describes the provisions of this program:

Where the POC indicates the need for Personal Care services, each participant will be provided a choice between the traditional vendor or the Personal Choices option. The participant is the employer of record for the services they choose to self-direct. During the planning process, services and supports will be identified to meet the participant's individual needs and may include State plan services, generic resources and natural support networks in addition to waiver services. At the time of the planning process, the TA Waiver Case Manager will ensure that the participant and caregiver have sufficient information available to make informed choices about participation in the Personal Choices Program.

Personal Choices Program workers must comply with the provisions within the Alabama Nurse Practice's Act.

Participants who choose to self-direct personal care services will be referred to a Financial Management Service Agency (FMSA) that will function as an intermediary between each participant and individuals who perform the self-directed services. The FMSA will assist the participant and/or representative to facilitate employment of workers. The FMSA will conduct the following tasks:

- Develop an enrollment packet for individuals that will provide personal care services;
- Perform background checks on perspective individuals who will provide personal care services;
- Provide information to assist in employment of workers;
- Manage and monitor on a monthly basis, all invoices from individual employees who provide waiver services against the amount of services authorized in the spending plan
- Develop fiscal accounting and expenditures reports;
- Report problems regarding participant directed services to the TA Waiver Case Manager;
- Work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's employees;
- Withhold federal, state, and local tax payments including FICA;
- File the necessary tax forms for the IRS and the State of Alabama;
- Provide the individual with the necessary tax information on a timely basis;
- File and withhold state unemployment insurance tax; and
- Make payments for invoices submitted by individuals or agencies providing personal care services.

The Personal Choices Counselor conducts an initial orientation session to provide an overview of the Participant Handbook that provides the participant with the tools they need to effectively and safely manage their services. The participants are informed of the roles and responsibilities of being an employer as well as the support functions of the TA Waiver Case Manager, the Personal Choices Counselor, and the FMSA.

Clients on the TA Waiver program will be provided greater opportunity to direct personal care services through one of two ways. Option one is the traditional TA Waiver services. The second option is the Personal Choices Program described under 1915(j) of the Social Security Act, which provides an alternative to the traditional provision for Personal Care Services. This option is available to all TA Waiver recipients Statewide. Under this option, the waiver participant will be responsible for identifying an individual to perform their Personal Care Services. The waiver participant will notify the counselor of their choice of Personal Care workers for consideration of employment. The FMSA will have the candidate complete an application for employment and will perform the background screening for each candidate prior to employment and provision of service. The review of timesheet will be the responsibility of the waiver recipient. The worker will submit completed timesheets directly to the FMSA. The FMSA would be responsible for monitoring all invoices for personal care services. The TA Waiver case manager will monitor the provision of participant-directed services through monthly home visits to ensure services are delivered and health and safety of the participant is not compromised. The FMSA will be monitored to the degree necessary to ensure compliance with appropriate fiscal and programmatic procedures.

The Personal Choices Program participant may choose to manage their own personal support plans, or may appoint a representative to assist them. All participants have an option of choosing one individual to act as a representative to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the

personal support plans or may be appointed during the duration of the waiver. The TA Waiver Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

The Alabama Medicaid Agency will maintain oversight of the following FMSA activities:

- Monitor the FMSA to the degree necessary to ensure compliance with appropriate fiscal and programmatic procedures;
- Implement data gathering processes to enable the AMA to create accurate reports to identify and prevent erroneous billing;
- Provide support to the FMSA to facilitate effective training and identify efficient financial accounting methods; and
- Monitor the cost of the self-directed services by reviewing the data from the CMS 372 Report on a quarterly basis.

The AMA will collect information from participants and providers regarding the satisfaction with the FMSA performance. This process may include focus groups, phone contacts and face-to-face interviews.

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

If the participant chooses to access the 1915(j) Personal Choices Program, they will be allowed to direct Personal Care Services. Participants may choose to manage their own services or may appoint a representative to assist them. The State elects to permit participants to hire legally liable relatives as paid providers of the personal care services identified in the service plan and budget. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for Personal Care Services.

Each individual that applies for the waiver program will be informed about the Personal Choices program option. Any individual who wishes to self-direct their services is given the opportunity to participate in the program. It is not based on the assessment.

Those who choose not to direct Personal Care Services will continue to receive their Personal Care Services through the traditional TA Waiver program.

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.

Under the 1915j-

The ADSS Counselor will conduct an initial orientation that begins with risks being identified along with risk mitigation plan development through the use of three primary tools: 1.) The Personal Choices Rights and Responsibilities, 2.) the Self-Assessment and 3.) the Risk Assessment Checklist. In addition, participants are provided the Personal Support Plan too. This plan assists them in identifying other resources that may be able to provide help, support, and also mitigate risk. The Personal Choices Participant Handbook provides a detailed description of the roles and responsibilities of the participant including a detailed description of the roles, responsibilities and support functions of the ADSS Counselor and the FMSA agency. This document will be thoroughly reviewed with the participant and/or representative to ensure that there is a clear understanding of the responsibilities related to the health, safety, and mitigation of risks to be assumed by the participant. The second tool is the Self-Assessment, which asks participants to indicate their understanding and ability to implement each of the roles and responsibilities detailed in the Personal Choices participant Handbook. Depending on the responses, the ADSS Counselor and participant will formulate a plan for ensuring the participant can effectively manage each of the roles and responsibilities. Other potential strategies may include additional training and/or the use of an informal or formal representative. The third tool is the Risk Assessment Checklist. This instrument lists many common risk factors, ranging from physical and cognitive disabilities to social issues such as isolation. For each identified risk, the participant is alerted to the nature of the potential risk and prompted with examples to develop a plan to mitigate that potential risk. The participant and/or responsible party signs a Personal Choices rights and responsibilities document and receives a detailed manual. This document and manual describes the potential risks and liabilities. It also informs them of their choice to withdraw at any time.

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

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:

If the participant chooses to access the 1915(j) Personal Choices Program, they 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 a representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plan or may be appointed during the duration of the waiver. The ADSS Counselor will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
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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:

Pursuant to the 1915j:
 The FMSA will enroll with ADSS as a provider. The FMSA will not provide any direct services. The participant’s budget is calculated by converting the eligible services in the waiver service plan to dollar amounts. The number of hours or units authorized for each service is multiplied by the current hourly or unit cost of the service. From this amount, 15% is allocated directly for administration expenses. This includes counseling and FMSA services. The 15% is usually less than the administrative costs that goes to a provider agency under the traditional program.

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

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

Pursuant to the 1915j:
 Alabama utilizes a Fiscal Employer Agent as our vendor for the Personal Choices Program. The vendor is selected through a Request For Proposal (RFP) procurement method. This procurement is for one vendor.

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

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

Specify:

Pursuant to the 1915j:
 Alabama utilizes a Fiscal Employer Agent as the vendor for the Personal Choices Program. The vendor is selected through a Request For Proposal (RFP) procurement method. This procurement is for one vendor.

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

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

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Pursuant to the 1915j:
 ADSS will monitor the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours of discovery. Remediation of the problem will be expected within 48 hours of the FMSA being notified by ADSS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

Pursuant to the 1915j:
 The State does not compensate entities for providing information. Assistance and information is received from either the FMSA, ADSS, or AMA. The Personal Choices program will provide participant protections to include: information to participants, participant training and skills assessment, counseling services, financial management services, development of emergency back-up plans, development of an incident reporting system and access to program staff. Participants are required to use counseling and financial management services in order to assume responsibility for their care and financial management. The ADSS Counselor will train, coach, and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget to effectively meet their care needs, avoid overspending as well as prevent the under-utilization of their allocated budget. The FMSA, as the employer agent, will assist participants to pay their employees and assure compliance with State and Federal labor and tax laws. The FMSA will provide a method of receiving funds from the State and making the funds available for the participant's budgets.

- Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care/Attendant Services	<input type="checkbox"/>
Private Duty Nursing	<input type="checkbox"/>
Pest Control Service	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Medical Supplies	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Pursuant to the 1915j:

The ADSS Counselor will provide information to the waiver participant to support their efforts to direct their own individual services. This will occur during the initial assessment process, during reviews and updates to the plan of care. If the individual elects to direct their own services, they will be referred to the FMSA to provide employer related services. These include:

- Developing an enrollment packet for individuals or agencies that will provide personal care services;
- Providing information to assist in employment of workers;
- 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 will be as follows:

- The FMSA will provide monthly reports to ADSS
- ADSS and/or AMA will perform on-site administrative and operational reviews
- AMA and ADSS will monitor the FMSA, on a monthly basis during the first six months of operations and every six months thereafter.

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

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

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)

I. 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:

Pursuant to the 1915j:

A program participant may elect to discontinue participation in the Personal Choices Program at any time. The AMA and ADSS 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 ADSS 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 ADSS Counselor will begin the disenrollment process within ten (10) business days from the date of notification.

A face-to-face contact is required by the TA Waiver Case Manager or the Counselor to discuss the following:

- To provide an opportunity for the Counselor to determine if the participant's health, safety, and welfare has been jeopardized during their enrollment
- 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 dis-enroll
- To explain the processes and timeline for return to the traditional service delivery option
- To ascertain the participant's choice of direct service providers
- To discuss the conversion of the individual budget back to traditionally authorized services and make necessary decisions related to accumulated funds.

From the receipt of the participant's request to discontinue their participation, the timeline for initiation of traditional waiver services may be from 15 to 45 days. The Counselor will have ten (10) days to begin the process of reinstating traditional waiver services. Personal Choices Program services will continue until traditional services 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.

Pursuant to the 1915j:

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, the participant will be returned to receiving traditional waiver services. Participants will be given advance notice in writing of their return to the traditional TA Waiver program. Although the decision to involuntarily disenroll the participant from the Personal Choice 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 ADSS 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 TA Waiver program in accordance with established Medicaid Fair Hearings provisions.

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

- Health, Safety and Well-Being: At any time that, the ADSS Counselor, the TA Waiver Case Manager, and/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.
- Misuse of Monthly Allocation: If the Personal Choices participant/representative choose the cash option and uses the monthly budgeted allocation to purchase items unrelated to personal care needs, fail to pay the salary of an employee, or fail to pay related State and Federal payroll taxes, the participant/representative will received a written warning notifying them that exceptions to the agreed upon conditions of participation are not allowed. The participant will be permitted to remain on the Personal Choices program, but expenditures will be monitored and reviewed closely by the ADSS Counselor and/or the Financial Management Services Agency (FMSA) to ensure the funds are being expended appropriately. The participant/representative will be notified in writing that further failure to misuse funds allocated through the Personal Choices program will result in involuntary disenrollment from the program.
- 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 the ADSS Counselor will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under-utilization of the budget allocation, the participant will be returned to traditional waiver services.
- Failure to Provide Required Documentation: If a program participant/representative fails to provide required documentation of expenditure and related items as prescribed in the Personal Choices Rights and Responsibilities tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program. The participant/representative 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. The participant/representative 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

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		10
Year 2		10
Year 3		10
Year 4		10
Year 5		10

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

- Specify additional staff qualifications based on participant needs and preferences so long as such**

qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

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

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to state limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the state's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:



Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Pursuant to the 1915j:

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

- A. Each recipients budget will be established based on the current hours of traditional personal care hours received each week. Of the total monthly amount, a flat fee will be directed to the FMSA for administration of the participant-directed personal care services. No other services will be available through this option. The primary choice for the recipient will be the decision regarding who will provide their personal care services.
- B. The number of hours that a recipient will receive is based on the individual assessment of need and will remain unchanged, unless the individuals need changes. All changes will be indicated on the waiver participants plan of care (POC). Each participant will be provided a form which will assist in determining the payment methodology and rate of pay for the personal care worker.
- C. Services are reviewed for appropriateness monthly during the case management home visit. Any additional factors identified during the home visit or by other means are based on the assessment of need and will be indicated on the recipients POC.
- D. Policy and procedures will describe the formula used to establish each recipients budget which will be applied consistently for each recipient who chooses the participant-directed option.
- E. Information about the budget methodology will be made available to the public through, ADSS website, as well as published materials, formal and informal oral presentations.

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

Each individual develops a spending plan based on the dollar amount of their participant-directed budget. The individual is provided a Participant Handbook that outlines in detail, the process of developing a spending plan. The handbook provides examples and guidance on the formulation of the spending plan. The Personal Choices Counselor meets with the individual and explains the process further along with the requirements of the program and addresses any questions they may have about the process. The individual determines who their employees will be, what services they need, whether there are goods and services they wish to purchase, whether they want to establish a savings account for specific items needed or whether they want to obtain some monies in cash to purchase smaller items. An excel based tool is provided to assist the client in calculating the dollar amounts for each category.

The purchase of goods and services are authorized under the 1915(j) option in the state plan. This service is not available as a waiver service to those who do not elect to self-direct using the 1915(j). Authority used:

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Pursuant to the 1915j:

The State informs each participant of the amount of their monthly budget and the procedures by which to request an adjustment in the budget amount during the development of the personal support plans. The participant will be notified of their personal care services during the service plan development process. The plan development process requires signatures of all members of the support team, including the individual if able, indicating the services have been reviewed and all involved are in agreement. The personal care services budget amount will be determined and the participant will be informed during the enrollment meeting with the ADSS Counselor. Requests for adjustments to the personal care services budget will go through the ADSS Counselor. ADSS will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate, employee overtime payment, employee bonuses etc. The personal care budget does not serve as a limit on the amount of waiver services that an individual may receive. The support team will determine the appropriate level of service and the personal care services budget will be built based on maximum units authorized. Budget changes will not be approved for purchase of waiver goods and services not authorized in the service plan.

A service plan would need to be finalized first in order for the budget amount to be determined as the budget amount is predicated on the numbers of hours the individual would receive under the traditional waiver program. The participant in the Personal Choices program is given the same appeal rights as any of our waiver programs. If any services are denied or reduced, they have the right to appeal. A notice of action would be provided to the participant and this form gives the participant instructions on how to request an appeal.

The assessment process determines the amount of the budget. Once the budget is established, the participant then has full control over who will provide personal care services. If in the future there are additional needs identified, the participant's budget can be adjusted to accommodate the need. Information for budget methodology may be made available to the public through ADSS' website, as well as, published material, formal and informal presentation.

The eligible services authorized under the traditional waiver program plan of care are converted into the dollar amount for the Personal Choices Program (the Personal Choices Budget). The participant has budget authority for the dollar amount identified for the Personal Choices Budget. Once provided the dollar amount, the participant utilizes the spending plan worksheet to develop their budget (called a spending plan in the Personal Choices Program). The participant has full budget authority in determining the allocation of the dollars for care under the Personal Choices Program within the established guidelines for the program.

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:

Pursuant to the 1915j:

The financial management activities will include:

- Identification of problems associated with the monthly allowance such as misuse or under-utilization of the funds;
- Participants/representative's failure to pay staff as required;
- Participant/representative's failure to comply with applicable state and federal laws;
- Participant/representative's failure to submit documentation of expenditures;

Theft of checks mailed to participants or other problems will be reported in writing to the AMA and ADSS.

The ADSS Counselor will train, coach and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget 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.

The Alabama Medicaid Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E, to persons who are denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. A hearing officer is made available by the Commissioner of the Alabama Medicaid Agency and conducts the hearings. If the individual/guardian is still dissatisfied after the Hearing, he/she may appeal to the Circuit Court. The TA Waiver participants are provided with the necessary information upon enrollment.

All individuals sign a statement as part of the HCBS initial assessment that certifies that they have been given to opportunity to choose between institutional or HCBS services. Each individual is provided a list of the available providers and have the Freedom of Choice to select from the available providers. The individual is provided notification of their rights to appeal at the initial meeting for enrollment and application to the program.

The ADSS Targeted Case Manager explains the procedures when services have been reduced, suspended, denied or terminated under the waiver and sends a 10-day advance notice to the participant prior to the reduction or termination of services. The notice includes:

1. A description of the action the agency intends to take,
2. The reasons for the intended action,
3. Information about the participants rights to request as hearing, and
4. An explanation of the circumstances under which Medicaid services will continue if a hearing is requested.

A copy of the written plan of care includes information on the appeal rights and the steps to appeal an adverse decision. A copy of the information is left in the participants home. 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 notice of action (letter notifying recipient of the informal conference outcome). 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. The participant or legally appointed representative or other authorized person must request the hearing and give a correct mailing address to receive future correspondence. 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 or she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearing will be forwarded and a hearing date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw, the participant or legally appointed representative or other authorized person should write the AMA that he or she wishes to do so and give the reason for withdrawing.

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 is responsible for ensuring that the waiver participant has the right to request an appeal of any decision which adversely affects his or her eligibility status for receipt of services and/or assistance.

The ADSS Targeted Case Manager sends the participant a ten day advance notice prior to the reduction, suspension, denial or termination of services. The participant, applicant, or his/her legal representative can request an Informal Conference if they disagree with the notice of action. To initiate the Informal Conference or a review of the case, the participant, applicant, or his/her legal representative must send a written request to the AMA Program Manager within 30 days from the date of the notice action. If the individual is not satisfied with the decision made by the AMA, a written request for a hearing must be received no later than 30 days from the date of the Informal Conference.

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 Alabama Medicaid Agency (AMA) is responsible for the operation of the grievance/complaint system. The AMA ensures that the ADSS Targeted Case Manager and direct service provider (DSP) fulfill their duty of properly informing the participant of all rights and responsibilities and the manner in which service complaints may be registered. Complaints filed by the recipients may be reported directly to the Alabama Medicaid Agency. A tracking log is used to document the incidents and the resolution and maintained at the 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).

(a) The participant may register grievances/complaints about due process, education, complaints, safe and humane environment, protection from harm, privacy/confidentiality, personal possessions, communication and social contacts; religion; confidentiality of records; labor; disclosures of services available; quality treatment; individualized treatment; participating in planning for treatment, least restrictive conditions and informed consent.

(b) Complaints of abuse, neglect or treatment are investigated immediately, referred to the responsible division and an investigation is initiated by the direct service provider and the Alabama Medicaid Agency. Any other complaints are opened and responsible parties notified within 24 hours and investigations are initiated as soon as possible but no later than seven working days of the report, with the explanation that resolution will be achieved within 14 working days.

(c) The AMA investigates all complaints upon receipt of notification. Appropriate parties initiate action within 24 hours if it appears that a participants health and safety is at risk, immediate steps will be taken. If necessary, the complainant is interviewed.

(d) The ADSS Targeted Case Manager with the AMA Nurse Reviewer will ensure that no health and safety risk exists. The AMA contacts the participant via telephone to ensure that full resolution to the incident has been completed satisfactory. The AMA TA Waiver Coordinator maintains all grievance logs and reviews them on a quarterly basis. The AMA TA Waiver Coordinator is responsible for tracking and assuring that complaints have been followed to resolution.

ADSS provides information to the clients enrolled in the program regarding their rights to express a grievance or complaint and the procedure to follow. The information provides detail regarding the ability of the client to make a complaint and their ability to request a fair hearing if their complaint/grievance is not resolved to their satisfaction.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)

No. This Appendix does not apply (do not complete Items b through e)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Reporting Requirements:

Incident Types Timeframes

Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Death	Immediate
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

All Medicaid approved providers of services for Medicaid recipients in their homes shall report incidents of abuse, neglect, and exploitation immediately to the department of Human resources, law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act deals specifically with abuse, neglect, and exploitation of adults who are incapable of protecting themselves. The law outlines the responsibilities of the Department of Human Resources, law enforcement authorities, physicians, caregivers, individuals, and agencies in reporting and investigating such cases, and in providing necessary services.

Physicians, osteopaths, chiropractors, and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse.

Those required to report must do so immediately on finding reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation. Reports must be made either to the chief of police or sheriff, the county Department of Human resources or call 1-800-458-7214. An oral report, either by telephone or in person, must be made first. It must be followed by a written report.

Other incidents such as falls must be reported within 24 hours to the provider Agency, the Alabama Medicaid Agency , and Alabama Department of Senior Services. Follow-up will be handled timely based upon the circumstances surrounding the incident.

- 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.

Training and information are provided by the ADSS Targeted Case Manager and the direct service provider to participants and /or families or legal representatives concerning abuse, neglect, and exploitation. The ADSS Targeted Case Managers maintain relationships with waiver participants to encourage them to talk about what is important to them, including what may be happening that they do not like. Each participant is informed of his/her rights and responsibilities. If the participant is not able to understand these rights, responsibilities and protections, and the means by which these protections are enforced, the legal guardian/advocate is informed of them.

All participants are given education at the time of enrollment in the program regarding how to report abuse, neglect, or exploitation. All information is readdressed with the clients at the time of annual redetermination. The Targeted Case Manager would also re-iterate this information if there is any suspicion that something is occurring with the client. In addition, Alabama has developed an Elder Abuse Toolkit that is available at the AAA to use in education regarding ANE.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The AMA is the entity that receives reports of critical events or incidents. The AMA TA Waiver Coordinator reviews the critical events reports and asks for additional information if necessary to assure resolution within seven working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse, neglect or exploitation are investigated. If the AMA TA Waiver Coordinator determines that an incident requires follow-up, she will coordinate the efforts and assign a completion date not to exceed 30 days based on the nature of the incident.

The AMA receives reports of critical events or incidents through the Gateway Portal. The AMA TA Waiver Coordinator reviews the critical events reports and asks for additional information if necessary to assure resolution within seven working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse, neglect or exploitation are investigated. If the AMA TA Waiver Coordinator determines that an incident requires follow-up, she will coordinate the efforts and assign 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 AMA is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants through individual/family interviews, annual participation satisfaction surveys, review of complaint logs, medical record reviews, DSP personnel record reviews and onsite home and provider visits when deemed necessary.

The TA Waiver Coordinator looks for patterns of incidents and how the incident could have possibly been prevented. The TA Waiver Coordinator works closely with the case managers to ensure safety measures are observed during monthly visits to help prevent possible incidents. These oversight activities are conducted weekly.

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 (ADSS) Services will monitor the unauthorized use of restraints or seclusion during the monthly face-to-face visits. Alabama Medicaid Agency (AMA) will monitor through Satisfaction Surveys and the established Complaint and Grievance process. Additionally, the ADSS and AMA will monitor when onsite visits are conducted.

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) will monitor the unauthorized use of restrictive interventions during monthly face-to-face visits. The Alabama Medicaid Agency (AMA) will monitor during Satisfaction Surveys and through the established Complaint and Grievance process. Additionally, the ADSS and AMA will monitor when onsite visits are conducted.

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 (ADSS) Services will monitor for seclusion during the monthly face-to-face visits. Alabama Medicaid Agency (AMA) will monitor through Satisfaction Surveys and the established Complaint and Grievance process. Additionally, the ADSS and AMA will monitor when onsite visits are conducted.

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 instances of 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 survey respondents who reported their health and safety needs are being met in the home

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measure:
Number and percent of critical incidents, by type, investigated and completed within the time frame specified

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 investigations closed effectively and resolved within 60 days

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<div style="border: 1px solid black; width: 100%; height: 40px; margin-top: 10px;"></div>

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 records reviewed where alternative procedures were implemented appropriately instead of restrictive interventions

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>

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 service providers who successfully complete the annual refresher training which included a session on abuse, neglect, mistreatment, and exploitation.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="provider"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

AMA TA Waiver Coordinator will ensure that all reported instances of abuse or neglect are investigated and will track the number of substantiated allegations.

AMA TA Waiver Coordinator will ensure that recommendations included in investigative reports are implemented as required. AMA TA Waiver Coordinator will review and analyze critical incident data at the individual, provider and state levels. All findings related to the participant safeguards will be documented and communicated to the ADSS Targeted Case Manager and service provider as appropriate for corrective action.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Complaints that AMA receives are documented on a log. The DSP is required to inform the participant/responsible party of their right to register a complaint with the ADSS Targeted Case Manager and the AMA. AMA TA Waiver Coordinator will conduct reviews of complaints received by the DSP during audits of the providers.

The TA Waiver Coordinator reviews case records and identifies problems that could be indicative of a systemic problem. If multiple participates are experiencing the same acute condition or critical incident, ADSS and the targeted case manager would be notified to investigate further and follow up with their findings.

ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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.

Since AMA is the Operating Agency for the TA Waiver, it is responsible for maintaining data regarding the quality of services provided from various sources. The Quality Framework is used as a guide to assess seven Program Design Focus areas from samples of waiver participants, case management and direct service providers records, on-site home visits, and onsite visits to direct service providers. In addition, 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 participant's satisfaction with resolutions.

Data is collected through annual record reviews, DSP policies and procedures, DSP 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 is reviewed to ensure that basic and continuing education requirements are met. Home visits are 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. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is maintained quarterly and annually. AMA in collaboration with the LTC Division, will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access:

- Sources of data
- Case Management Records
- Home Visits
- DSS Queries
- Consumer Surveys

Participant Centered Service Planning and Delivery:

- Sources of data
- Consumer Surveys
- Case Management Records
- Site Visits
- Home Visits

Provider Capacity and Capabilities:

- Sources of data
- Consumer Surveys
- Case Management Records
- Personnel and Training Records of DSPs
- Home Visits

Participants Safeguards:

- Sources of data
- Case Management Records
- Consumer Surveys
- Home Visits
- Site Visits

Participants Rights and Responsibilities:
 Sources of data
 Consumer Surveys
 Case Management Records
 Complaint and Grievances Logs
 Targeted Surveys

Patient Satisfaction:
 Sources of data
 Consumer Surveys
 Case Management Records
 Home Visits
 Site Visits

System Performance:
 Sources of data
 Review of Operating Agency Quality Assurance System
 Review of Operating Agency Billing and Service Provision
 Collaborative Meeting with Operating Agency to enhance the administration of the Program
 Subcontractor Client Records

The following indicators are monitored and maintained by the AMA Operating Agency:

- Percentage of participant’s reporting satisfaction with waiver services and needs met.
- Percentage of participant’s reporting they feel safe and secure in the home and community.
- Percentage of participant’s reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of participant’s reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the participant’s needs and preferences.
- Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

AMA conducts quarterly meetings with all Operating Agencies to discuss data/findings and develop strategies to improve or correct systems. Follow-up meetings and trainings are to implement changes and updates. Both ADSS and AMA are involved in system improvements.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>

b. System Design Changes

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Alabama Medicaid Agency (AMA) is responsible for collecting data regarding the quality of services provided from various sources. The data collected specifically addresses the performance measures associated with each assurance. The data is further broken down to show percentage of compliance for each area. The TA Waiver Coordinator reviews the following reports for data related to the six assurances:

Critical incident reports are monitored and reviewed per occurrence for the type, harm, education, and resolution. Targeted case managers update the Gateway portal with any critical incident. The TA Waiver Coordinator reviews all critical incidents in the Gateway portal.

Expert Scan Data Reports provide data on returned participant satisfaction surveys. This report is monitored and reviewed quarterly for complaints, overall satisfaction with the program, and resolution of any issues. A targeted survey is sent to ensure all issues/complaints are resolved satisfactorily.

Participant Plans of care are reviewed in an ongoing manner for initial participants and annually for participants already on the program. The plans of care are reviewed for accuracy, timely updates related to changes in the participant's condition, changes in service hours, changes in services, needs, and assessed preferences.

Annual Qualified Providers Report details all providers for TA Waiver participants to include their current enrollment status and licensure.

Review Data Sheet Reports for billing to ensure payment is for services that are approved and provided during annual participant re-determinations and on-site audits.

Monitor ADSS for operations and performance as issues/concerns arise and during their annual on-site audit. During annual audits, if deficient practice is observed; then the TA Waiver Coordinator will collect all reports, record review documentation, and notations from interviews with administrative staff to compile all information needed to substantiate the deficiency. The administrative staff will be notified of the deficiency and the need for a corrective action plan during the exit conference. A letter describing the deficient practice will be mailed with instructions for the agency to provide the AMA with a corrective action plan within 15 days of receipt of the letter. If the corrective action plan is received timely and is appropriate for the findings, a letter is sent indicating the corrective action plan is acceptable. During the next annual audit, the TA Waiver Coordinator will check to ensure continued compliance with the corrective action plan for the deficient practice.

The TA Waiver Coordinator, AMA's Long Term Care Division, Alabama Department of Senior Services (ADSS), and targeted case managers will meet quarterly to discuss measuring performance and making improvements that have been discovered or are on indicator reports.

Data is collected using quality indicators from each of the seven Program Design Focus areas of the Quality Framework as a guide. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participant's satisfaction with resolutions. This data is also tracked in Expert Scan software.

Priorities are established based on the severity of the critical incident. The AMA assesses each critical incident in the Gateway portal to see if the incident could have been avoided. If not, what needs to be put in place to prevent the incident from occurring again in the future? AMA will follow up with ADSS to ensure a resolution has been initiated to ensure the health and safety of all TA Waiver participants.

The TA Waiver Coordinator, LTC Division, and ADSS will meet quarterly to discuss development of strategies and implementation of system improvements. After meeting with the appropriate agencies, the TA Waiver Coordinator will compile the strategies discussed and send an email to agencies for their input.

Gateway is software that can be modified to accommodate the changing needs of waiver staff in utilizing this software to review and sign off on critical incidents.

Notification of TA Waiver participants is during the face-to-face monthly targeted case manager visit. The families and participants are notified of any changes in the program that will take place verbally and with certified letters. They are provided with specific time lines related to any upcoming changes. Their input is always vital to the AMA.

Certified letters are sent to service providers and other interested parties to update them on any program changes. The AMA's website, news outlets, and AMA District Offices are updated with any changes that may affect the TA Waiver.

The AMA website is updated to include any changes or updates to the waiver. It is available to the public.

The make-up of the Quality Improvement Strategy includes the following:

- development of plans of care
- how well case management is functioning
- how well our providers score on certification
- participant satisfaction survey results

The state monitors and analyzes the effectiveness of systems quarterly. This process includes review of report data for accuracy. Review of the Gateway software to ensure access and complete data entry and sign off.

Revisions to the QIS are ongoing as changes in quality improvement are identified. Information about performance is used to identify and prioritize areas of system improvements by determining how the particular performance can be improved through education, training, or corrective action plan. The priority level will rise depending on the scope and severity of the performance compliance. The process that the state will follow to assess the effectiveness of both the system improvement and the QIS is through monitoring of statistical data for each performance measure that shows if there is improvement or a decline in that area. This will provide valuable insight into the need to improve our operation and performance of this particular performance measure. Revision of the approach and design is necessary and appropriate to achieve compliance.

Reports and EVVM System
 The TA Waiver Coordinator shall run quarterly queries to determine the types, frequency, outcomes, and resolutions of critical incidents utilizing the Gateway Portal. The targeted case managers have access to input all critical incidents into the Gateway Portal per occurrence.
 The following reports shall be generated to monitor trends:
 Critical Incident Reports
 Data Sheet Reports
 Provider enrollment and licensure Report
 Expert Scan (Participant Survey) Report

The AMA has selected First Data as its vendor to provide Electronic Visit Verification Monitoring (EVVM) services. Once approved by CMS, this system will give us better tracking of hours billed by direct service providers for in home services.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The TA Waiver Coordinator reviews the yearly Participant Satisfaction Surveys and the Quality Assurance Indicator reports. Remediation for non-compliance issues and complaints identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the severity of the complaint will be evaluated and appropriate action will be taken.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- No
- Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for

waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Alabama Medicaid Agency has contracted with Hewlett Packard Enterprise(HPE)to serve as the claims payment contractor. HPE reviews the claim for Medicaid eligibility before reimbursing providers. The Alabama Medicaid Agency conducts financial audits of Medicaid providers and issues exceptions when it identifies areas of non-compliance with the States policy requirements. The State of Alabama Public Examiners conduct financial audits of the waiver program.

Medicaid's post-payment financial audit program for the Waiver is designed to ascertain that only reasonable and allowable expenses are included. The auditor will conduct a sampling process of the providers 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 and cancelled checks, vendor invoices, and all vouchers or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditors findings and opinion regarding compliance and internal control.

Financial accountability and review is part of the retrospective reviews. The State selects 5% of applications for review. This is higher than what was recommended by the Raosoft sample size calculator that is used to determine the percentage. According to the calculator we only need 3.8% to yield a 5% error rate and 95% confidence level.

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 as specified in the waiver document

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 claims that are paid at the posted rate

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<i>Specify:</i> <input type="text"/>		<i>Describe Group:</i> <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other <i>Specify:</i> <input type="text"/>
	<input type="checkbox"/> Other <i>Specify:</i> <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other <i>Specify:</i> <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other <i>Specify:</i> <input type="text"/>

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

The fiscal agent for AMA has edits in the system to ensure that the participant has Medicaid financial eligibility and TA Waiver eligibility before claims are paid.
 To ensure timely payment to providers AMA is notified of any claims payment issues and will work with HPE to resolve them as quickly as possible.
 AMA through internal claims queries can track payments and denials for each waiver participant, as well as the cost of the entire waiver program.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

If problems with claims are identified, the AMA TA Waiver Coordinator will notify the appropriate Agency staff to review the claim, and send the provider a letter to readjust the claim or the AMA will recoup the money.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No**
- Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The AMA is responsible for establishing provider payment rates for waiver services. Payments made by Medicaid to TA Waiver providers are on a fee-for-service basis and are based upon a number of factors:

- 1. Current pricing for similar services,*
- 2. State-to-State comparisons,*
- 3. Geographical comparisons,*
Geographical comparisons within the state, and
Comparisons of different payers for similar services.

For each waiver service, a procedure code is used with a rate assigned to each code. The Medicaid Management Information System (MMIS) pays the claim based upon the States pre-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index. A fee schedule for services is available on the Medicaid website. Public and/or participant feedback regarding rates is possible through satisfaction surveys, email, or a telephone call.

Keeping rates at a level consistent with similar providers in other programs allows the agency to ensure there are enough providers to provide services and allow for an individual's freedom of choice. There are rural areas of the state that are difficult to staff. The agency recruits providers diligently for these areas. The addition of Self-direction to this program will offer more opportunities in areas where the providers are limited.

- 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:*

The AMA makes payments directly to the provider of waiver services through the States Medicaid Management Information System (MMIS). There are provider agreements between Medicaid and each provider of service under the waiver.

A provider has to apply to the agency to be a provider, there is an onsite inspection, and training to use the MMIS system. Providers have access to the MMIS system in their place of business. They electronically submit claims, using approved procedure codes and units, to the fiscal intermediary which processes payment.

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:

Medicaid will make payments directly to providers of waiver services. There will be a provider agreement between Medicaid and each provider of waiver services. Payment for all waiver services will be made through an approved MMIS. Medicaid pays providers through the same fiscal agent used in the rest of the Medicaid program.

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:

ADSS provides Targeted Case Management which includes transitional assistance services available through the Medicaid State Plan.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.*
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).*

Specify the governmental agency (or agencies) to which reassignment may be made.

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:

- 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:

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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	32269.00	18290.00	50559.00	101607.00	7105.00	108712.00	58153.00
2	37125.00	18838.00	55963.00	104655.00	7318.00	111973.00	56010.00
3	45769.00	19403.00	65172.00	107794.00	7537.00	115331.00	50159.00
4	54581.00	19985.00	74566.00	111028.00	7763.00	118791.00	44225.00
5	55406.00	20585.00	75991.00	114359.00	7996.00	122355.00	46364.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	80		80
Year 2	80		80
Year 3	80		80
Year 4	80		80
Year 5	80		80

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 311 days per year based upon the most recent CMS 372 report (Lag 2018-2019).

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:

Using most recent CMS 372 report and adding 3% inflation per year.
 Historical service utilization rates are used to predict future utilization rates. Historical data is defined as recent (2014-2015) 372 data and internal claims queries

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:

Using most recent CMS 372 Lag (2018-2019)report and adding 3% inflation per year.
 Historical service utilization rates are used to predict future utilization rates. Historical data is defined as recent 372 data and internal claims queries
 The State's MMIS system has edits in place to deny any claims for dual eligibles that are covered by or partially covered by other parties. Therefore, only eligible services are included in the estimate for D'.

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:

Using most recent CMS 372 initial report (2019-2020)and adding 3% inflation per year.
 Historical service utilization rates are used to predict future utilization rates. Historical data is defined as recent 372 data and internal claims queries

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:

Using most recent CMS 372 initial report (2019-2020)and adding 3% inflation per year.
 Historical service utilization rates are used to predict future utilization rates. Historical data is defined as recent 372 data and internal claims queries.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Personal Care/Attendant Services	
Assistive Technology	
Medical Supplies	
Pest Control Service	
Private Duty Nursing	

Appendix J: Cost Neutrality Demonstration

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services Total:							241500.00
Personal Care/Attendant Services	<input type="checkbox"/>	Per 15 minutes	35	2300.00	3.00	241500.00	
Assistive Technology Total:							105000.00
Assistive Technology	<input type="checkbox"/>	As needed	15	1.00	7000.00	105000.00	
Medical Supplies Total:							54000.00
Medical Supplies	<input type="checkbox"/>	Monthly	30	12.00	150.00	54000.00	
Pest Control Service Total:							7500.00
Pest Control Service	<input type="checkbox"/>	As needed	3	1.00	2500.00	7500.00	
Private Duty Nursing Total:							2173500.00
Private Duty Nursing	<input type="checkbox"/>	Per Hour	35	2300.00	27.00	2173500.00	
GRAND TOTAL:							2581500.00
Total: Services included in capitation:							
Total: Services not included in capitation:							2581500.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							32269.00
Services included in capitation:							
Services not included in capitation:							32269.00
Average Length of Stay on the Waiver:							311

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services Total:							310500.00
Personal Care/Attendant Services	<input type="checkbox"/>	Per 15 minutes	45	2300.00	3.00	310500.00	
Assistive Technology Total:							105000.00
Assistive Technology	<input type="checkbox"/>	As needed	15	1.00	7000.00	105000.00	
Medical Supplies Total:							63000.00
Medical Supplies	<input type="checkbox"/>	Monthly	35	12.00	150.00	63000.00	
Pest Control Service Total:							7500.00
Pest Control Service	<input type="checkbox"/>	As needed	3	1.00	2500.00	7500.00	
Private Duty Nursing Total:							2484000.00
Private Duty Nursing	<input type="checkbox"/>	Per Hour	40	2300.00	27.00	2484000.00	
GRAND TOTAL:							2970000.00
Total: Services included in capitation:							2970000.00
Total: Services not included in capitation:							2970000.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							37125.00
Services included in capitation:							37125.00
Services not included in capitation:							37125.00
Average Length of Stay on the Waiver:							311

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services Total:							363000.00
GRAND TOTAL:							3661500.00
Total: Services included in capitation:							3661500.00
Total: Services not included in capitation:							3661500.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							45769.00
Services included in capitation:							45769.00
Services not included in capitation:							45769.00
Average Length of Stay on the Waiver:							311

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services	<input type="checkbox"/>	Per 15 minutes	55	2200.00	3.00	363000.00	
Assistive Technology Total:							105000.00
Assistive Technology	<input type="checkbox"/>	As needed	15	1.00	7000.00	105000.00	
Medical Supplies Total:							81000.00
Medical Supplies	<input type="checkbox"/>	Monthly	45	12.00	150.00	81000.00	
Pest Control Service Total:							7500.00
Pest Control Service	<input type="checkbox"/>	As needed	3	1.00	2500.00	7500.00	
Private Duty Nursing Total:							3105000.00
Private Duty Nursing	<input type="checkbox"/>	Per Hour	50	2300.00	27.00	3105000.00	
GRAND TOTAL:							3661500.00
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							3661500.00
<i>Total Estimated Unduplicated Participants:</i>							80
<i>Factor D (Divide total by number of participants):</i>							45769.00
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							45769.00
<i>Average Length of Stay on the Waiver:</i>							311

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services Total:							429000.00
Personal Care/Attendant Services	<input type="checkbox"/>	Per 15 minutes	65	2200.00	3.00	429000.00	
GRAND TOTAL:							4366500.00
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							4366500.00
<i>Total Estimated Unduplicated Participants:</i>							80
<i>Factor D (Divide total by number of participants):</i>							54581.00
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							54581.00
<i>Average Length of Stay on the Waiver:</i>							311

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:							105000.00
Assistive Technology	<input type="checkbox"/>	As needed	15	1.00	7000.00	105000.00	
Medical Supplies Total:							99000.00
Medical Supplies	<input type="checkbox"/>	Monthly	55	12.00	150.00	99000.00	
Pest Control Service Total:							7500.00
Pest Control Service	<input type="checkbox"/>	As needed	3	1.00	2500.00	7500.00	
Private Duty Nursing Total:							3726000.00
Private Duty Nursing	<input type="checkbox"/>	Per Hour	60	2300.00	27.00	3726000.00	
GRAND TOTAL:							4366500.00
Total: Services included in capitation:							
Total: Services not included in capitation:							4366500.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							54581.00
Services included in capitation:							
Services not included in capitation:							54581.00
Average Length of Stay on the Waiver:							311

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care/Attendant Services Total:							495000.00
Personal Care/Attendant Services	<input type="checkbox"/>	Per 15 minutes	75	2200.00	3.00	495000.00	
Assistive Technology Total:							105000.00
GRAND TOTAL:							4432500.00
Total: Services included in capitation:							
Total: Services not included in capitation:							4432500.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							55406.00
Services included in capitation:							
Services not included in capitation:							55406.00
Average Length of Stay on the Waiver:							311

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	<input type="checkbox"/>	As needed	15	1.00	7000.00	105000.00	
Medical Supplies Total:							99000.00
Medical Supplies	<input type="checkbox"/>	Monthly	55	12.00	150.00	99000.00	
Pest Control Service Total:							7500.00
Pest Control Service	<input type="checkbox"/>	As needed	3	1.00	2500.00	7500.00	
Private Duty Nursing Total:							3726000.00
Private Duty Nursing	<input type="checkbox"/>	Per Hour	60	2300.00	27.00	3726000.00	
GRAND TOTAL:							4432500.00
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							4432500.00
Total Estimated Unduplicated Participants:							80
Factor D (Divide total by number of participants):							55406.00
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							55406.00
Average Length of Stay on the Waiver:							311