CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: 11-W-00365/4

TITLE: Community Waiver Program

AWARDEE: Alabama Medicaid Agency

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived, shall apply to the demonstration project from October 21, 2021 through September 30, 2026. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STC).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted for the Alabama Community Waiver Program section 1115 demonstration, subject to the STCs.

1. Comparability **Section 1902(a)(17)**

To the extent necessary, to enable Alabama to establish annual expenditure caps and enrollment groups within the 1915(c) waiver.

2. Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To the extent necessary, to enable Alabama to offer a different package of services and/or the same services with different amount, duration, and/or scope to the different enrollment groups within the one 1915(c) waiver.

3. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary, to enable Alabama to reallocate the overall annual unduplicated available slots between the four 1915(c) waiver enrollment groups and the expenditure authority group and between the five regions.

4. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable Alabama to limit the freedom of choice of providers for Support Coordination services to staff employed by the Alabama Department of Mental Health (ADMH), Division of Developmental Disabilities (DDD), for counties where the Community Waiver Program will operate in Regions 1, 3, 4, and 5 and to limit Support Coordination services to willing and qualified public corporations (that do not have a conflict of interest) outlined in STC 28, that contract with ADMH, known as 310 Boards, for counties where the Community Waiver Program will operate in Region 2 (or ADMH/DDD if no willing and qualified 310 Boards are available).

To the extent necessary, to enable Alabama to limit the number of preferred providers for services authorized in the 1915(c) waiver to maintain sufficient provider capacity as described in the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00365/4

TITLE: Community Waiver Program

AWARDEE: Alabama Medicaid Agency

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, shall, for the period of this demonstration period beginning from October 21, 2021 through September 30, 2026, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authority will enable Alabama to implement the Community Waiver Program section 1115 demonstration:

1. **Home and Community Based Services (HCBS) Population Group 5**

   Expenditures for HCBS and related support services, as described in Special Terms and Conditions (STC) 21, for Medicaid beneficiaries who are eligible under the Medicaid state plan and meet the eligibility qualifications as described in STC 20. These beneficiaries will be known as "Section 1115 Group 5".

Title XIX requirements not applicable to the demonstration eligible expenditure group:

1. **Statewideness** **Section 1902(a)(1)**

   To the extent necessary, to enable Alabama to limit the geographic areas of the Community Waiver Program for the expenditure group.

2. **Comparability** **Section 1902(a)(17)**

   To the extent necessary, to enable Alabama to establish annual expenditure caps for the expenditure group.

3. **Reasonable Promptness** **Section 1902(a)(8)**

   To the extent necessary, to enable Alabama to reallocate the overall annual unduplicated available slots between the four 1915(c) waiver enrollment groups and the expenditure authority group and between the five regions.

4. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary, to enable Alabama to limit the freedom of choice of providers for Support Coordination services to staff employed by the Alabama Department of Mental Health (ADMH), Division of Developmental Disabilities (DDD), for counties

where the Community Waiver Program will operate in Regions 1, 3, 4, and 5 as outlined in STC 28 and to limit Support Coordination services to willing and qualified public corporations (that do not have a conflict of interest), that contract with ADMH, known as 310 Boards, for counties where the Community Waiver Program will operate in Region 2 (or ADMH/DDD if no willing and qualified 310 Boards are available).

To the extent necessary, to enable Alabama to limit the number of preferred providers for service as per STC 30 to maintain sufficient provider capacity as described in the STCs.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00358/6

TITLE: Community Waiver Program

AWARDEE: Alabama Medicaid Agency

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Community Waiver Program" section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Alabama Medicaid Agency (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state waivers of requirements under section 1902(a) of the Social Security Act (the Act). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The Community Waiver Program demonstration is approved for a five-year period from October 21, 2021 through September 30, 2026.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Cost Sharing
VII. Delivery System
VIII. HCBS Quality Assurance and Reporting Requirements
IX. General Reporting Requirements
X. Evaluation of the Demonstration
XI. General Financial Requirements
XII. Monitoring Budget Neutrality
XIII. Schedule of Deliverables for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs:

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Evaluation Report
Attachment C: Evaluation Design (reserved)
Attachment D: Preferred Provider Qualifications
Attachment E: Home and Community-Based Services Definitions for Section 1115 Group 5
Attachment F: Quality Improvement Systems Performance Measures

II. PROGRAM DESCRIPTION AND OBJECTIVES

Alabama's Community Waiver Program section 1115 demonstration will overlay specific waiver and expenditure authorities over a new 1915(c) waiver to allow the state flexibility to operate a new home and community-based services (HCBS) program. The Community Waiver Program will establish five distinct enrollment groups between the 1915(c) waiver and section 1115 demonstration. Each enrollment group is determined by age, documentation of an intellectual disability (ID), the level of care needed, and living situation (with family, independent, or in a residential support setting). Each enrollment group will be eligible for a distinct package of services and will be subject to an annual expenditure cap for such benefits.

With this approval, Alabama seeks to achieve multiple goals and objectives including, but not limited to the following:

- Improve access to care by reducing and eventually eliminating the current waiting list for HCBS.
- Keep families together, support independent living, and provide increased opportunities for self-direction.
- Adopt a strategy for delivering HCBS that aims to prevent crisis and escalation of needs for individuals who do not currently require an institutional level of care.
- Support the capacities that individuals with ID have to contribute to their community through participation in integrated community employment, while also better ensuring their financial stability in continuing to live in the community.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly waived in the waiver document (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived. In addition, CMS reserves the right to amend the STCs to reflect such changes

and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
   b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received

and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
d. An up-to-date CHIP allotment worksheet, if necessary; and
e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.
b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out

activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also

comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation.** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

16. **Populations Affected by the Demonstration.** Only beneficiaries with intellectual disabilities eligible for Medicaid through the state plan, or who would be Medicaid-eligible if they were in an institution, in addition to meeting level of care criteria of the 1915(c) waiver, or for the section 1115 group 5, requiring HCBS but not meeting level of care criteria, will be subject to the provisions within this demonstration. The 1915(c) waiver (AL.1746) and STC 20 specify the eligibility groups. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly authorized in this demonstration and as described in these STCs.

17. **Population Groups.** The 1915(c) waiver will establish four enrollment groups and the section 1115 demonstration will establish one enrollment group. Each enrollment group will be based on the age of the beneficiary, documentation of an ID, the level of care needed, and living arrangement of the beneficiary:

a. 1915(c) Group 1: Children with ID, ages 3-13, meeting 1915(c) level of care, living with family or other natural supports.
b. 1915(c) Group 2: Transition age youth with ID, ages 14-21, meeting 1915(c) level of care, living with family or other natural supports; or for those ages 18-21, living independently.
c. 1915(c) Group 3: Adults with ID, ages 22 and older, meeting 1915(c) level of care, living with family or other natural supports, living independently, or able to live in a non-intensive supported living arrangement.
d. 1915(c) Group 4: Individuals with ID, ages 3 and over, meeting 1915(c) level of care and not able to live with family or other natural supports, not able to live independently and not able to live in a non-intensive supported living arrangement.
e. Section 1115 Group 5: Adults with ID, ages 22 and older, requiring HCBS but not yet meeting an institutional level of care, living with family or other natural supports or living independently.

18. Enrollment Caps. Over the course of the demonstration approval period, the state will have an overall annual unduplicated enrollment cap as approved in Appendix B-3 of the 1915(c) waiver (AL.1746), which includes the enrollment caps for the 1915(c) and section 1115 enrollment groups. The state will limit the enrollment to align with available resources, initially establishing a total of 500 slots across the enrollment groups. The state intends to proportionally allocate the slots for each enrollment group across the five demonstration areas based on the total percentage of waiting list individuals who live within the demonstration area.

Beneficiaries currently receiving services under the state's two existing 1915(c) waivers – the Alabama Home and Community Based Waiver for Persons with Intellectual Disabilities (ID waiver) and the Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH waiver) – may voluntarily transition to the new Community Waiver Program 1915(c) waiver after the new waiver has been operational for at least twenty-four (24) months. If beneficiaries transition from the ID or LAH waiver to the new 1915(c) waiver, their funding and their slots will transition with them into the Community Waiver Program, even if the program is at the maximum capacity specified in the new 1915(c) waiver (AL.1746). The beneficiaries who transition from the ID or LAH waivers into the Community Waiver Program would not take up the allotted slots specified in Appendix B-3 of the 1915(c) waiver (AL.1746).

19. Enrollment Priority. The state will establish enrollment priority categories for enrollment in the demonstration:

- Priority 1: On waiting list; age 21 and older (no access to Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] and/or public education/special education); goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment if under age 65.
- Priority 2: On waiting list; age 21 and older (no access to EPSDT and/or public education/special education); goal to preserve current family/independent living situation.
- Priority 3: Not on waiting list; age 21 and older (no access to EPSDT and/or public education/special education); goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment if under age 65.

- Priority 4: Not on waiting list; age 21 and older (no access to EPSDT and/or public education/special education); goal to preserve current family/independent living situation
- Priority 5: On waiting list; transition age 16-21 (EPSDT and/or public education/special education still available); goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment at exit from high school.
- Priority 6: Not on waiting list; transition age 16-21 (EPSDT and/or public education/special education still available); goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment at exit from high school.

20. Eligibility Criteria. Each enrollment group will be subject to the eligibility criteria as approved in the 1915(c) waiver and as identified in these STCs for the section 1115 group 5.

a. The section 1115 group 5 will be subject to all service definitions (Attachment E), person-centered service planning (STC 23), provider qualifications (Attachment D and E), quality improvement system (Attachment F) and other provisions, unless explicitly excluded in these STCs.
b. The section 1115 group 5 includes individuals who are eligible for Medicaid under the state plan who meet the needs-based criteria and targeting requirements listed below in STC 20(c) and have income at or below 150 percent FPL. The section 1115 group 5 also provides Medicaid eligibility for individuals who are not otherwise eligible for Medicaid, have income at or below 250 percent FPL, and meet the needs-based criteria and targeting requirements listed below in STC 20(c).
c. The section 1115 group 5 will include individuals who:
    i. Have an intellectual disability as evidenced by an IQ score below 70 that manifests before age 18;
    ii. Are current age 22 or over;
    iii. Need HCBS but do not yet meet an institutional level of care; and
    iv. Have substantial functional limitation in one or more of the following adaptive skills areas as measured by an Inventory for Client Agency Planning (ICAP) assessment which results in at least one skills area scored less than or equal to 480:
        - Communication
        - Self-care
        - Home living
        - Social skills
        - Community use
        - Self-direction
        - Health and safety
        - Functional academics
        - Leisure
        - Work

The Alabama Department of Mental Health (ADMH), Division of Developmental Disabilities (DDD) must conduct an independent assessment of needs through evaluations and annual re-evaluations to determine if an individual meets/continues to meet the eligibility criteria of the section 1115 group 5.

V. BENEFITS

21. Benefits for Beneficiaries in the Demonstration. Beneficiaries in each enrollment group, including beneficiaries within the section 1115 group 5, will receive the following services and supports, as approved in the 1915(c) waiver and demonstration. Specific service and supports definitions, including limitations on the amount, duration, and frequency, are described and authorized in the AL.1746 1915(c) waiver for groups 1 through 4 and in Attachment E for group 5.

Table 1. Services and Supports by Enrollment Group					
Services and Supports	**1915(c) Group 1**	**1915(c) Group 2**	**1915(c) Group 3**	**1915(c) Group 4**	**Section 1115 Group 5**
Support Coordination	X	X	X	X	X
Supported Employment Individual*- Exploration; Discovery; Job Development Plan; Job Development; Job Coaching; Career Advancement		X	X	X	X
Co-Worker Supports		X	X	X	X
Supported Employment-Small Group		X	X	X	X
Integrated Employment Path Services		X	X	X	X
Financial Literacy and Work Incentives Counseling		X	X	X	X
Community Transportation*	X	X	X	X	X
Independent Living Skills*	X	X	X		X
Personal Assistance Home*	X	X	X		
Community Integration Connections and Skills Training*			X	X	X
Personal Assistance Community*	X	X	X	X	
Peer Specialist Services		X	X	X	X
Family Empowerment and Systems Navigation Counseling	X	X	X		

Table 1. Services and Supports by Enrollment Group					
Services and Supports	**1915(c) Group 1**	**1915(c) Group 2**	**1915(c) Group 3**	**1915(c) Group 4**	**Section 1115 Group 5**
Natural Support or Caregiver Education and Training	X	X	X		
Breaks and Opportunities (Respite)*	X	X	X		
Assistive Technology and Adaptive Aids	X	X	X	X	X
Remote Supports		X	X	X	X
Housing Counseling Services		X	X	X	X
Housing Start-Up Assistance		X	X	X	X
Minor Home Modifications (not included in expenditure cap)	X	X	X		
Supported Living Services			X	X	
Adult Family Home				X	
Community-Based Residential Services				X	
Individual Directed Goods and Services*	X	X	X	X	X
Positive Behavior Supports	X	X	X	X	
Physical Therapy		X	X	X	
Occupational Therapy		X	X	X	
Speech and Language Therapy		X	X	X	
Skilled Nursing*		X	X		

**Denotes services that can be self-directed.*

22. Non-duplication of Services. HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including federal, state, local, and private entities.

23. Person-centered Planning. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with the HCBS regulations at 42 CFR 441.301(c)(1) and the written person-centered service plan must meet the federal requirements in regulations 42 CFR 441.301(c)(2). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR

441.365(e) at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

24. **Expenditure Caps**. Each population group will be subject to an annual expenditure cap, which is subject to individual increases where the state determines either an emergency situation exists, or that it would be cost effective to allow a higher cap for a beneficiary to avoid more expensive residential or institutional services. Expenditure caps will reset every enrollment year for each beneficiary. The enrollment year is established based on the enrollment date. If a beneficiary leaves the program, but returns within the same enrollment year, his/her expenditure cap for the remainder of that enrollment year will consist of the remaining unexpended funds available to the individual for that enrollment year. Each annual expenditure cap applies to a new enrollment year.

Table 2. Annual Expenditure Caps by Population Group	
Population Group	**Annual Expenditure Cap**
1915(c) Group 1	$12,000
1915(c) Group 2	$15,000
1915(c) Group 3	$30,000- Living with family or natural supports $45,000- Living in own home/apartment
1915(c) Group 4	$65,000 $100,000- Exceptional medical and/or behavioral needs
Section 1115 Group 5	$22,000

All annual expenditure caps exclude minor home modifications.

VI. COST SHARING

25. **Premiums and Cost Sharing for Beneficiaries in the Demonstration.** Cost sharing for beneficiaries in this demonstration must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost sharing set forth in 42 CFR 447.56(a).

VII. DELIVERY SYSTEM

26. **Delivery System.** Demonstration beneficiaries will receive services through the same fee-for-service arrangements as currently authorized in the state.

27. **Demonstration Areas.** The demonstration will operate in five ADMH regions, which will include the following eleven counties.
    - Region 1: Madison, Morgan, and Limestone counties
    - Region 2: Tuscaloosa and Walker counties
    - Region 3: Baldwin and Mobile counties
    - Region 4: Montgomery, Elmore, and Houston counties
    - Region 5: Jefferson county

28. **Support Coordination Services.** The state will establish provider qualifications for support coordination services. Support coordination services will be provided by staff employed by

the ADMH/DDD for demonstration counties in Regions 1, 3, 4, and 5. Support coordination services will be provided by ADMH/DDD or, in Region 2 by willing and qualified 310 Boards[1] for demonstration counties.

29. Preferred Provider Qualifications. The state will establish preferred provider qualifications for most services to limit the provider network for services in the demonstration based on certain preferred qualifications as described in Attachment D, providers' prospective capacity and the needs of enrollees. Providers may qualify as a preferred provider if they meet the scoring criteria as proposed by the state, which includes scoring the highest up to the number needed to provide choice of at least 2 providers per service, as described in Attachment D, and provide supporting documentation of such qualification to the state. The following services do not require a provider to meet the preferred provider qualifications:

- Any service that is self-directed by the participant or his/her representative;
- Natural Support and Caregiver Education and Training;
- Community transportation;
- Minor home modifications;
- Physical therapy;
- Occupation therapy; and
- Speech and language therapy.

When a beneficiary transitions from the LAH waiver or ID waiver into the Community Waiver Program, if the beneficiary's provider is not already a preferred provider in the Community Waiver Program, the provider will be required to apply as a qualified provider in the new program. Upon successful application, transferring providers will only be approved to serve the transitioning beneficiary from the ID or LAH waiver. To serve all Community Waiver Program beneficiaries, the provider will be required to compete and be selected in a subsequent RFP process. Transferring providers who do not meet the minimum scoring criteria for a preferred provider, described in Attachment D, will have a six-month grace period to come into compliance with the scoring criteria if: (1) at application the provider meets a minimum score of nine and up to eleven, and (2) the transferring provider contractually agrees to receive technical assistance from the state during the grace period to help the provider achieve the minimum qualifying score, described in Attachment D. During this grace period, transferring providers will only be allowed to serve the transferring beneficiary from the LAH or ID waiver. After the grace period, if they successfully achieve the minimum qualifying score to be a preferred provider, as described in Attachment D, they will be permitted to compete and be selected in a subsequent RFP process to serve all Community Waiver Program beneficiaries. Individuals transferring from the ID or LAH waiver will sign acknowledgement that they understand his/her provider may not qualify to be a permanent provider in the Community Waiver Program prior to the transfer.

30. Preferred Provider Selection. The state will limit the number of preferred providers for most services authorized in the 1915(c) waiver while maintaining sufficient provider capacity

[1] Alabama Act 310 provides for the formation of public corporations to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services.

in each region, with a minimum of two providers per service in each region of the Community Waiver Program. To assess needed capacity, the state will examine existing provider capacity, projected new enrollments, and expected service utilization. A single provider may qualify as one of the two possible providers for multiple services in multiple regions, but can never occupy both provider slots for a single service in any region. Providers will be selected based on the preferred provider qualification score, service need, reported provider capacity, and results of competitive RFP process. Providers who apply and meet the preferred provider qualifications but are not selected due to additional capacity needs being met through selection of higher scoring providers will be considered for placement on the "Stand-by list." The state will select a minimum of at least one provider per service for each region, who meets the minimum preferred qualifications, but was not selected in the initial request for proposal (RFP) process to be on a "reserved stand by list" to be available when provider capacity changes and there is a need based on monitoring. Each individual will always have at least two providers to select from for services so, to the extent necessary to provide choice, an additional provider will be named to be on the "reserved stand by list". The state will monitor the provider capacity on a monthly and quarterly basis and will increase the number of preferred providers per each impacted service, by region, when any of the following occur:

a. Quarterly average referral acceptance rate drops below 80 percent during a public health emergency (PHE) or drops below 90 percent in all other periods. The quarterly average referral acceptance rate will be defined for each specific service in each region as follows: of the total number of beneficiaries referred to one or more providers for the service during the quarter in a region, the percentage whose referrals were accepted by a provider during the quarter and up to fourteen (14) calendar days beyond the end date of the quarter. This data will be collected by the support coordination providers.
    i. Numerator: Total number of beneficiaries whose referrals were accepted by a provider during the quarter and up to fourteen (14) calendar days beyond the end date of the quarter in each region.
    ii. Denominator: Total number of beneficiaries referred to one or more providers for the service during the quarter in each region.
b. Quarterly average timeframe from referral acceptance to service initiation exceeds sixty (60) days during a PHE or exceeds forty-five (45) calendar days in all other periods. The quarterly average timeframe from referral acceptance to service initiation will be defined for each specific service in each region as follows: the average number of days from referral acceptance to service initiation across total number of beneficiaries who had the service initiated for them during the quarter in that region. The timeframes will be calculated by provider reported data and support coordination providers.
    i. Numerator: Cumulative number of days from referral acceptance to service initiation for all service initiations in the quarter specific to the service type and region.
    ii. Denominator: Total number of service initiations in the quarter specific to the service type and region.
c. Monthly, ADMH/DDD will track, through electronic Support Coordination system, timely referral acceptance rates by providers and, through claims and monthly reports from providers, timely service initiation after acceptance of a referral. The state will review these data sources to confirm contracted providers of each service in a region continue to have capacity to provide the service to current enrollees and anticipated new enrollees who will use the service. When one or more providers report they are unable

to expand the number of beneficiaries they are serving in a particular service and region to meet anticipated demand, or when the quarterly reports (described in a or b above) demonstrate delays in provider acceptance or service initiation, the state will initiate the process to increase the number of providers for the impacted service and region.

The amount of additional provider capacity needed will be based on existing and anticipated need for the particular service, in each region. The state will determine how much additional capacity is needed by:

a. Identifying how many beneficiaries did not have a referral accepted during the quarter under review;
b. Identifying how many beneficiaries had a referral accepted, but did not have timely service initiation, as defined in section b. above, during the quarter under review;
c. Determining anticipated need for additional capacity based on state's plan to expand total enrollment slots in the region within the next twelve months and calculating projected service utilization rates based on existing service utilization rates in the region, among Community Waiver Program beneficiaries; and
d. Doubling the total additional capacity needed as a result of a, b and c above, and ensuring this capacity exists within a minimum of two providers, to preserve choice of provider for Community Waiver Program beneficiaries.

When a new RFP process has to occur, after the demonstration start date, due to additional capacity needs for current enrollees, the state will begin to maintain a "Stand-by list" of at least one provider per service for each region who can be immediately enrolled into the Community Waiver Program, to timely provide services to current beneficiaries when additional capacity needs are identified, while the RFP process is occurring.

Once the state has determined there is a need for additional capacity for a particular service in a particular region, the state will release an RFP. RFP respondents that are approved for selection consideration must all meet the preferred provider qualifications described in Attachment D. Providers who apply and meet the preferred provider qualifications but are not selected due to additional capacity needs being met through selection of higher scoring providers, will be considered for placement on the "Stand-by list." A minimum of one provider, based on the highest score, will be put on the "Stand-by list" for purposes described above. The remaining providers who met the preferred provider qualifications but were not selected for immediate contracting or placement on the "Stand-by list" will have their proposals held in priority status. The priority status will allow these providers to compete in the next RFP process for the same service and region by completing an attestation confirming the continued accuracy and completeness of their original proposal, with the option to submit additional information to further support their proposal. This priority status will relieve the provider of the responsibility to resubmit an entirely new application when the next RFP process is announced by the state.

Referral and referral acceptance data will be collected in real time by support coordination providers. All other providers will report service initiation and provider capacity data to the state on a monthly basis, due ten (10) business after the end of the reporting month. The monthly provider reports will document each beneficiary for whom they initiated a new service, the beneficiary's county/region, the type of new service initiated, and the date the new service was initiated. The monthly report will also document an estimate of the number

of new beneficiaries that provider has the capacity to serve by service type and county/region. The state will assess the provider capacity based on the criteria above within twenty (20) business days of the end of the reporting quarter and, if necessary, will increase the number of preferred providers for each impacted service by region. The state will report their monitoring process and any changes to the number of preferred providers in the quarterly monitoring reports submitted to CMS as per STC 41. When a beneficiary transitions from the ID or LAH waivers in to the Community Waiver Program, their referral acceptances and timeframes to service initiation will only be included in the regional service-specific evaluation of provider network adequacy for new services added to their person-centered plan after enrollment in the program.

VIII. HCBS QUALTY ASSURANCE AND REPORTING REQUIREMENTS

31. HCBS Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

32. HCBS Settings Requirements. The state must assure compliance with the characteristics of HCBS settings as described in the 1915(c) regulations in accordance with implementation/effective dates as published in the Federal Register.

33. Quality Reporting Requirements. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. NOTE: This information will be submitted in conjunction with reporting for the concurrent 1915(c) waiver (AL.1746) and the state's other 1915(c) waivers for individuals with ID, and could also be included in the annual reports detail in STC 41.

34. Deficiencies Reporting Requirements. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. NOTE: This information will be submitted in conjunction with reporting for the concurrent 1915(c) waiver (AL.1746) and for the state's other 1915(c) waivers for individuals with ID, and could also be included in the annual reports detail in STC 41.

35. Conflict of Interest. The state agrees that entities that provide services is external to the agency or agencies that conduct service planning with the individual, as required under 1915(c) regulations. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

36. Self-Direction. Each beneficiary eligible for long term services and supports (LTSS) will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options.

37. Community Participation. The state must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

IX. GENERAL REPORTING REQUIREMENTS

38. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty (30) calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).
b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other

deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

39. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

40. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:
    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
    c. Submit deliverables to the appropriate system as directed by CMS.
41. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report in each demonstration year beginning in DY 1 and through DY 5. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.
    a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
    b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's goals, and must cover all key policies under this demonstration, including HCBS. Per 42 CFR 431.428, the Monitoring Reports must document the effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The monitoring and performance metrics must be included in the Monitoring Reports, and will follow—as applicable—the framework provided by CMS to support federal tracking and analysis.
    c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report

that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

42. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

43. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
d. The final Close-Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.
e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 38.

44. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

45. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

46. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 38.

47. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. The independent party will also support the state in the development of the Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

48. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS technical assistance on applying robust evaluation approaches, including establishing robust comparison groups and assuring causal inferences in demonstration evaluations.

49. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment C to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the

Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the evaluation design in monitoring reports.

50. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on Medicaid program sustainability.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

51. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

52. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a

renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.
e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

53. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. Upon approval from CMS, the revised Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

54. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

55. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

56. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid and ADMH websites within thirty (30) calendar days of approval by CMS.

57. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over

which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS

58. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[2]

59. Unallowable Expenditures. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any room and board costs for home and community-based services.

60. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

61. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

[2] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

62. Sources of Non-Federal Share. The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

63. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain one hundred (100) percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating

expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

64. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

65. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 3: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Section 1115 Group 5	Hypo 1	X		X	Adults with ID, ages 22 and older, requiring HCBS but not yet meeting an institutional level of care, living with family or other natural supports or living independently.

66. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-003654/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 4: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Section 1115 Group 5	Adults with ID, ages 22 and older, requiring HCBS but not yet meeting an institutional level of care, living with family or other natural supports or living independently.	See STC 59	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	10/21/2021	9/30/2026

67. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 5: Demonstration Years		
Demonstration Year 1	October 21, 2021 to September 30, 2022	12 months
Demonstration Year 2	October 1, 2022 to September 30, 2023	12 months
Demonstration Year 3	October 1, 2023 to September 30, 2024	12 months
Demonstration Year 4	October 1, 2024 to September 30, 2025	12 months
Demonstration Year 5	October 1, 2025 to September 30, 2026	12 months

68. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XII. CMS will provide technical assistance, upon request.[3]

[3] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

69. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

70. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XII. MONITORING BUDGET NEUTRALITY

71. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

72. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

73. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

74. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

75. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

76. Hypothetical Budget Neutrality Test 1: Section 1115 Group 5 HCBS (see Expenditure Authority #1). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6: Hypothetical Budget Neutrality Test									
MEG	**PC or Agg***	**WOW Only, WW Only, or Both**	**BASE YEAR [2021]**	**TREND**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Section 1115 Group 5	PC	Both	$1,833	4.6%	$1,833	$1,917	$2,006	$2,098	$2,194

77. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

78. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from October 21, 2021 to September 30, 2026. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

79. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 7: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

Table 8: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
180 calendar days after approval date	Draft Evaluation Design	STC 48
60 calendar days after receipt of CMS comments	Revised Draft Evaluation Design	STC 49
30 calendar days after CMS Approval	Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report published to state's website	STC 55
September 30, 2025, or with renewal application	Draft Interim Evaluation Report	STC 52
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 52
Within 18 months after June 30, 2026	Draft Summative Evaluation Report	STC 53
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 53
Monthly Deliverables	Monitoring Call	STC 44
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 41
	Quarterly Budget Neutrality Reports	STC 41(c)
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 41

Attachment A
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation design, the state should contact its demonstration team.

Expectations for Evaluation Designs

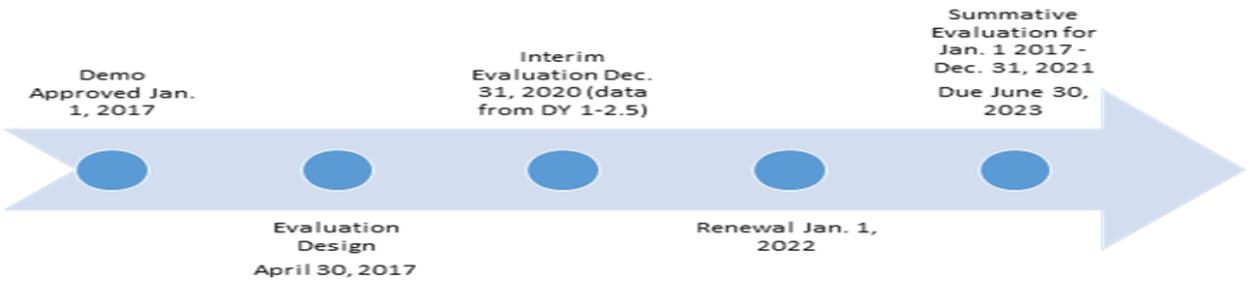
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of a deliverables timeline for a 5-year demonstration.) In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

a. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

b. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

c. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

d. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes;

e. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

a. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

c. Identify the state's hypotheses about the outcomes of the demonstration:
    i. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
    ii. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

a. *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
b. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
c. *Evaluation Period* – Describe the time periods for which data will be included.
d. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

- The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
- Qualitative analysis methods may be used, and must be described in detail.
- Benchmarking and comparisons to national and state standards, should be used, where appropriate.
- Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

- Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

e. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

f. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

   i. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

   ii. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

   iii. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

   iv. The application of sensitivity analyses, as appropriate, should be considered.

g. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

a. **Special Methodological Considerations** – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:
When the demonstration is:
1) Long-standing, non-complex, unchanged, or
2) Has previously been rigorously evaluated and found to be successful, or
3) Could now be considered standard Medicaid policy (CMS published regulations or guidance)

When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
1) Operating smoothly without administrative changes; and
2) No or minimal appeals and grievances; and
3) No state issues with CMS-64 reporting or budget neutrality; and
4) No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

a. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.

b. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

c. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B:
Preparing the Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

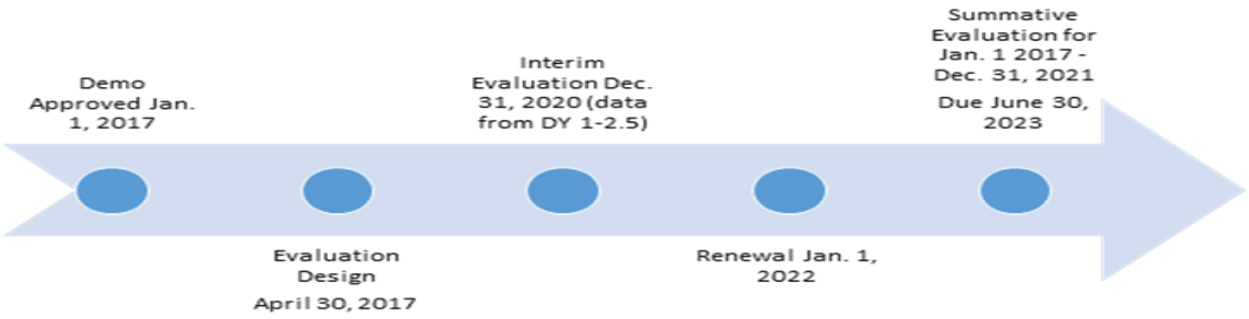
The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of a deliverables timeline for a 5-year demonstration.) In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how.

Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected
4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised

demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?

2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C:
Evaluation Design (reserved)

Attachment D:
Preferred Provider Qualifications

Each Preferred Provider Qualification is weighted on a score from 2 to 5 based on the relevant strength of the indicator in predicting the provider's ability to deliver Community Waiver Program services effectively.

- Minimum score to be a Preferred Provider = twelve (12) resulting from a positive score in at least three of the five factors identified below to qualify.
- Exception for providers serving a beneficiary that voluntarily transitions from the ID or LAH waiver into the Community Waiver Program: If the transferring provider does not meet the minimum score of twelve (12), but does score between nine (9) and eleven (11), the transferring provider will have a six-month grace period to achieve a minimum score of twelve (12), resulting from a positive score in at least three of the five factors; but only if the transferring provider contractually agrees to receive technical assistance from the state during the grace period to help the provider achieve the minimum qualifying score. During this grace period, the transferring provider will only be allowed to serve the transferring beneficiary from the ID or LAH waiver. After the grace period, if they successfully achieve the minimum qualifying score to be a preferred provider, as described in Attachment D, they will be permitted to compete and be selected in a subsequent RFP process to serve all Community Waiver Program beneficiaries. Maximum possible score is fifty (50)
- Requires adherence to a minimum of one component in three of the following factors to qualify.

I. Experience with Waiver Service Provision

A. The provider currently participates in the ID or LAH Section 1915(c) waiver programs for individuals with ID, and its most recent certification score was 90 percent or higher, placing it on a two-year review cycle. (5)

B. The provider is a contracted provider of HCBS for individuals with ID in another state or the ADMH Autism program. (3)

C. The provider employs or contracts with an appropriately licensed professional(s) in one (1) or more specialty areas (behavioral services, occupational therapy, physical therapy, speech language pathology, orientation and mobility, nurse education, training, and delegation) and this professional's role will involve training and/or consultation with direct support staff employed by the provider in supporting individuals with intellectual disabilities enrolled in the Community Waiver Program as verified by the provider's proposed staffing chart for the Community Waiver Program and the licensed professional's position description(s) or contract(s). (3)

II. Independent Accreditation

A. The provider holds accreditation, or is actively seeking accreditation ("actively seeking" means applied for and paid for accreditation within three months of applying to be part of the Community Waiver Program network) from any of the following nationally recognized accrediting bodies (4):

1. Commission on Accreditation of Rehabilitation Facilities minimum provisional accreditation
2. Council on Quality and Leadership (CQL) accreditation in at least one of the following:
    i. Quality Assurance Accreditation,
    ii. Personal-Centered Excellence Accreditation, or
    iii. Person-Centered Excellence w/ Distinction Accreditation
3. Council on Accreditation (COA) accreditation for Private Organization covering, at minimum, services for people with intellectual and developmental disabilities.

B. The provider has obtained Systemic, Therapeutic, Assessment, Resources, and Treatment (START) program certification, START network partner certification, or has at least one staff person who has completed START coordination certification and whose time will be at least 50 percent dedicated to serving referrals from the Community Waiver Program, as verified by the provider's proposed staffing chart for the Community Waiver Program. (3)

III. Support of Person-Centered Service Delivery

A. The provider has demonstrated leadership in assisting individuals with intellectual disabilities to pursue their interests and goals in their local community through community involvement, participation, and contribution, verifiable by documentation of outcomes achieved by individuals with ID (a random sample of 5 percent - minimum 5 persons) served by the organization. (3)

B. The provider has policies and processes in place to support individuals served to exercise choice with regard to direct support staff assigned to work with them; and the provider has a strategic goal (and documented plan with evidence of implementation occurring) to increase the extent to which individuals served have choice with regard to direct support staff assigned to work with them. (3)

C. The provider is willing and able to recruit and provide staff who are linguistically competent in spoken languages other than English when one of these languages is the primary language of individuals enrolled in the Community Waiver Program and/or their primary caregivers, verifiable by provider policy and staff position descriptions/contracts. (2)

D. The provider is willing and able to assign staff that are trained in the use of augmentative communication aids or methods in order to achieve effective communication with individuals enrolled in the Community Waiver Program and/or their primary caregivers, verifiable by provider policy and staff position descriptions/contracts. (2)

IV. Support of Independent Living

A. The provider has documented experience of providing HCBS to individuals with intellectual disabilities in their own homes or family/natural support homes (not owned or leased by a provider of services) and in integrated community settings (not in provider owned or operated non-residential facilities), verifiable by provider policy, existing HCBS contract(s), and service delivery records. (4)

B. The provider has assisted a person(s) supported by the agency in residential services to successfully transition into an independent or supported living arrangement, verifiable by provider policy, case examples and service delivery records. (4)

V. Support of Integrated, Competitive Employment and Community Inclusion

A. The provider has experience assisting individuals with intellectual disabilities to obtain and/or maintain individualized, competitive, integrated employment where an HCBS service provider is not the employer of record. This is evidenced by the provider's data, for a three-month period with an end date within six months of applying to become a Community Waiver program provider, showing the percentage of individuals with intellectual disabilities served (regardless of services provided) who are working in individualized, competitive, integrated employment is at least 15 percent. (4)

B. The provider is a contracted provider for Alabama Department of Rehabilitation Services. (4)

C. The provider can demonstrate relationships with other non-disability specific and non-Medicaid funded community organizations, associations and/or businesses that can be leveraged to assist individuals with ID in pursuing and achieving employment and integrated community involvement goals, as evidenced by at least three letters of commitment from such community-based organizations to work with the providers in order to help persons supported by the provider to achieve such goals. Three letters of commitment are required per county that the provider is applying to serve through the Community Waiver Program. Letters of commitment from other ID, LAH, Community Waiver Program, Autism or mental health service providers will not be counted. (4)

D. The provider is a consumer-led organization with a board of directors, more than 50 percent of whom have developmental disabilities. (2)

Attachment E:
Home and Community-Based Services Definitions for Section 1115 Group 5

1. **Support Coordination -** A case management and comprehensive supports/services coordination role involving direct assistance with gaining access to Section 1115 Group 5 services that are desired by and selected by the individual, from among available services that are effective options for meeting one or more assessed needs. Support Coordination also involves the effective coordination of Section 1115 Group 5 services with other Medicaid-funded services, other publicly-funded services and programs (e.g. Alabama Division of Rehabilitation Services (ADRS), school, workforce and generic community services), and other generic community services and resources (e.g. social, educational, religious, etc.) available to the individual, and family as applicable, regardless of the funding source.

   Support Coordinators (SC) are responsible for:

   - Conducting a comprehensive assessment of the individual, using both strengths and needs-based assessment tools provided by the Division of Developmental Disabilities (DDD), in collaboration with the individual and others that know the individual well
   - Engaging with the individual (and legal representative/involved family members, as applicable) to accurately identify the individual's vision for his/her life and key goals/outcomes the individual wants to achieve
   - Providing education to individuals (and legal representatives/involved family as applicable) about the various services and supports available through the Section 1115 Group 5 that are effective options for enabling the individual to achieve each of the key goals/outcomes identified by the individual (and legal representative/involved family members, as applicable)
   - Providing education to individuals (and legal representatives/involved family as applicable) about the option to self-direct certain services and supports that are available through the 1115 Group 5
   - Providing education to individuals (and legal representatives/involved family as applicable) about the available providers for each service and support available through the 1115 Group 5
   - Coordinating a person-centered planning process, consistent with the HCBS Settings Rule requirements, and developing a written person-centered plan (PCP), utilizing a template provided by DDD, which defines and documents:
     - The individual's goals/outcomes desired by the individual as part of his/her vision for a good and full life
     - The individual's needs related to achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life
     - The natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her with achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life
     - The types and amounts of Section 1115 Group 5 services and supports that are needed, in addition to the natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her, in order to ensure the individual can achieve his/her identified goals/outcomes which are considered necessary for achieving his/her vision for a good and full life

  - The setting in which the individual chooses to receive each Section 1115 Group 5 service, chosen from among setting options that are also documented in the PCP, including at least one non-disability specific setting option for each service
  - The individual's choices regarding the option to self-direct certain services and supports that are included in the PCP
  - The individual's choice of provider for each service and support included in the PCP that will not be self-directed
  - Ensuring the person is aware of their rights, including choice of providers. Secures the person's signature on the Free-Choice of Qualified and Contracted Providers form and provides the Dissatisfaction with Services Form
  - Any modification(s) to HCBS Settings Rule requirements that may be necessary consistent with federal requirements for including such modification(s) in the PCP
- Undertaking ongoing monitoring of the provision, adequacy, quality and effectiveness of Section 1115 Group 5 services/supports included in the person's PCP and progress toward goals/outcomes documented in the PCP
- Undertaking ongoing monitoring of the person's health, safety, and welfare
- Providing ongoing support and information, as needed, to individuals (and legal representatives/involved family as applicable) who choose to self-direct certain services and supports that are included in the PCP
- Coordinating services and supports over time, which preserve the individual's ability to live in a community setting
- Conducting evaluations specified by DDD related to continued functional and financial eligibility for the 1115 Group 5

There is a requirement of at least one (1) face-to-face visit with the person each month during the first twelve (12) months of enrollment and then quarterly after that time period, in addition to any other Support Coordination activities.

From the person-centered planning process, informed by the requisite assessments, the individual and the SC identify supports and services to address desired goals and outcomes. The individual and SC first explore unpaid and natural supports, then supports and services from other systems and programs available to the individual, followed by services and supports funded by the Section 1115 Group 5, utilizing Section 1115 Group 5 funding as the funding source of last resort. When considering Section 1115 Group 5 services, the SC is required to assist the individual in evaluating the Section 1115 Group 5 services and supports that will most effectively meet the individual's desired goals, outcomes, and needs. SCs are trained to be skilled in explaining services and supports, including those available through generic community resources and other systems and programs.

Support Coordinators are required to document the individual's goals/outcomes, needs, and preferences that are identified through a collaborative review of assessment results and exploratory discussion involving the individual's person-centered planning team. Prior to concluding the PCP development process, SCs must review their documentation of all the planning conversations with the individual to ensure the PCP meets all the person's identified needs and preferences related to their identified goals and outcomes.

When an individual chooses not to address one of their needs or preferences on the PCP, the SC discusses this choice with the individual. If the individual elects to not address an identified need or preference through the Section 1115 Group 5 PCP, this conversation must be documented, including the Support Coordinator's effort to encourage the individual to address the need. In cases wherein, the unaddressed need is related to health and safety or presents another type of risk, the SC completes the document, "Risk Agreement – Section 1115 Group 5" with the individual to document information and resources provided to the individual.

Support Coordination Supervisors are required to ensure that the PCPs developed by their SCs meet the needs of the individual as required by this Section 1115 Group 5 and Section 1115 Group 5 program policy and work instructions.

Person Centered Plans are subject to continuous revision, as needed. However, at a minimum, the PCP is reviewed by the individual and SC during a formal review at least annually. During this time, the individual's progress on the goals and outcomes identified on the previous year's PCP is reviewed as a priority. The individual and SC collaborate to ensure the new PCP is an accurate and current reflection of the individual's goals/outcomes and needs related to these goals/outcomes, and that the PCP adequately supports the individual's goals and outcomes with 1115 Group 5–funded services used to wrap around generic community services and supports and services and supports available through other programs and systems. When the cost of an individual's needs exceeds the person's expenditure cap, the SC is required to involve their Supervisor to review the PCP and assist the individual, as needed, in completing documentation for approval to exceed the expenditure cap (or receive approval for a one-time emergency expense) to avoid enrollment in an enrollment group with a higher expenditure cap, particularly to avoid residential placement if the person is living with natural supports or living independently.

Through the SC's monthly and quarterly contacts, the SC will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring for the individual and being effectively addressed by the person's providers of Section 1115 Group 5 services and supports.

It is also the SC's responsibility to review the provider's submitted documentation at least monthly, and note any problems, concerns, discrepancies, dramatic changes, or other occurrences that would indicate a need for review of the provider's performance or the individual's goals/outcomes or needs. The SC's review of the provider documentation will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk and/or if services are not being delivered according to the PCP.

This service identifies needs/goals related to decision-making, financial literacy, self-determination, but does not include provision of financial literacy education.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Support Coordinator	None	None	• Bachelor's degrees in human services field. Human Service field includes the following disciplines:

			Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill Development, or Basic Human Care Needs • Preference should be given to those with experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities as detailed in the service definition In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
DDD Certified Provider Agency: limited to any willing and qualified 310 Boards in counties where the Program will operate in Region 2	None	DDD Certification	<u>The Agency:</u> • Must be a Certified 310 Board servings counties where the Program will operate in Region 2 in good standing with DDD • Cannot provide any services other than monitoring and service plan development • No placement on Provisional status within the past 24 months; and • No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual

			and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

2. **Supported Employment - Individual** - A progression of services provided, as needed, on an individual basis for a person who, because of their disability(s), needs support to obtain and/or maintain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. These services are designed to support the achievement of individualized integrated employment outcomes consistent with the person's employment/career goals and conditions for success, as determined through Exploration and/or Discovery if such services are needed to accurately identify these goals and conditions.

   The expected outcome of this service is sustained paid employment in a competitive or customized job, with an employer who is not the person's service provider, and for which a person is compensated at or above the minimum wage, but not less than the customary wage paid by the employer for the same or similar work performed by persons without disabilities. The job also offers the level of benefits offered by the employer to persons without disabilities performing the same or similar work.

   Supported Employment - Individual Employment Support services are individualized and may include the following components:

   a. **Exploration** - A time-limited and targeted service designed to help a person make an informed choice about whether they wish to pursue an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or

above the minimum wage. Exploration shall be limited to no more than thirty (30) calendar days from the date of service initiation. This service is not appropriate for persons who know they want to pursue an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. The service includes introductory activities to identify a person's areas of specific interest, experience and skill related to individualized, integrated employment.

This service also includes exploration of employment opportunities that are specifically related to the person's identified interests, experiences, and/or skills through at least three uniquely arranged business tours, informational interviews, and/or job shadows. Each activity shall include time for set-up, prepping the person for participation in the activity, and debriefing with the person after each opportunity.

This service also includes introductory, basic education on the numerous work incentives for SSI and/or SSDI beneficiaries and how Supported Employment services work (including Vocational Rehabilitation services). The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report, on a template issued by the Department of Mental Health (DMH)/DDD, summarizing the process and outcomes, due no later than forty-five (45) calendar days after the service commences. Exploration is paid on an outcome basis, after the written report is received and approved.

b. Discovery - A time-limited and targeted service, if not otherwise available to the individual from the ADRS, designed to help a person, who wishes to pursue an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage to identify through person-centered assessment, planning, and exploration:

- Strong interests toward one or more specific aspects of the labor market
- Skills, strengths, and other contributions likely to be valuable to employers
- Conditions necessary for successful employment

Discovery may involve a comprehensive analysis of the person's history; interviews with family, friends, and support staff; observing the person performing work skills; and career research in order to determine the person's career interests, talents, skills, and support needs; and the writing of a Profile, a pre-assessment specific to the needs of Section 1115 Group 5-eligible persons, which may be paid for through the Section 1115 Group 5 in order to provide a valid assessment for Vocational Rehabilitation (VR) services to begin, which would begin with the development of an Employment Plan through ADRS.

Discovery shall be limited to no more than sixty (60) calendar days from the date of service initiation. The provider shall document each date of service, the activities performed that day, and the duration of each activity. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized, integrated employment. Discovery results in the production of a detailed written Profile, following content requirements established by DMH/DDD, summarizing the process, learning and recommendations for next steps. The written Profile is due no later than seventy-five (75) calendar days after the service commences. Discovery is paid on an outcome basis, after the

written Profile is received and approved.

c. Job Development Plan - A time-limited and targeted service, if otherwise not available to the individual from ADRS, designed to create a clear plan for Job Development to obtain an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is limited to thirty (30) calendar days from the date of service initiation. This service includes a planning meeting involving the person and other key people who will be instrumental in supporting the person to become employed in an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service may also include assistance with the submission of a Plan for Achieving Self Support (PASS) Plan to the Social Security Administration, depending on the needs of the individual. This service culminates in a written plan, on a template issued by DMH/DDD, directly tied to the results of Exploration, Discovery, as applicable when previously authorized, and is due no later than thirty (30) calendar days after the service commences.

d. Job Development - Job Development is a service, if otherwise not available to the individual from ADRS, that supports a person to obtain an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is designed to implement the Job Development Plan, if applicable, and should result in the achievement of an individualized, integrated employment outcome consistent with the person's employment and career goals, as determined through Exploration (if necessary), Discovery (if necessary) and/or the employment planning process and reflected in the PCP.

The Job Development strategy should reflect best practices and whether the person is seeking competitive or customized employment. This service will be paid on an outcome basis once an individualized, competitive, or customized job in an integrated community setting for which the person is compensated at or above the minimum wage has commenced, with payment tiered based upon the person's level of disability (Inventory for Client and Agency Planning (ICAP) score; additional assessment as identified by DMH/DDD).

e. Job Coaching - Job Coaching for individualized, integrated employment, if not otherwise available to the individual from ADRS, includes identifying and providing services and supports that assist the person in maintaining and advancing in individualized employment in an integrated setting. Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face. Job Coaching supports must be guided by a Job Coaching fading plan and must include systematic instruction utilizing task analysis to teach the person to independently complete as much of their job duties as possible.

<u>Examples of Job Coaching strategies that may be approved include:</u>

- Job analysis
- Job adaptations
- Instructional prompts
- Verbal instruction
- Self-management tools

- Physical assistance
- Role play
- Co-worker modeling
- Written instruction

Assistive Technology should also be introduced whenever possible to increase independence and productivity. Job Coaching also must include the engagement of natural supports (e.g., employers, supervisors, co-workers, or volunteers at the job site; or friends or family members in supportive roles) in the workplace to provide additional targeted supports that allow the job coach to maximize his/her ability to fade.

Job Coaching is not time-limited. The amount of time authorized for this service is a percentage of the person's hours worked, based on individual need. Payment per unit of service is tiered to encourage fading and is also based on the person's level of disability (ICAP score; DMH/DDD functional assessment) and the length of time the person has been employed.

This service cannot include payment for the supervisory and co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The use of this service shall be authorized on a time limited basis (i.e., no more than 180 calendar days) and reviewed to determine amount of service needed during next authorization period.

f. Career Advancement - A time-limited career planning and advancement support service, if not otherwise available to the individual from the ADRS, for persons currently engaged in individualized, integrated employment who wish to obtain a promotion and/or a second individualized, integrated employment opportunity. The service focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized, integrated employment or self-employment opportunity.

<u>The outcomes of this service are:</u>
- The identification of the person's specific career advancement objective
- Development of a viable plan to achieve this objective; and
- Implementation of the plan which results in the person successfully achieving his/her specific career advancement objective

<u>Career Advancement is paid on an outcome basis, after key milestones are accomplished:</u>
- Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. The written plan must follow the template prescribed by DMH/DDD.
- Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of forty (40) hours.

This service may not be included on a PCP if the PCP also includes any of the services that are also covered under Supported Employment - Individual Employment Support, except Job

Coaching. This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), and if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference(s), performance review(s) and/or good attendance record from current employer). The only exception is in situations where the provider who was previously authorized and paid for outcome payment number one did not also earn outcome payment number two because they did not successfully obtain a promotion or second job for the person. In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

- The Section 1115 Group 5 will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any Section 1115 Group 5 services. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment - Individual services, Supported Employment - Small Group, and/or Community Integration Connections and Skills Training.
- Transportation of the person to and from this service is not included in the rate paid for this service. Where staff delivering this service meet a person at his/her home to start the service, transportation of the person *to* this service is not necessary and shall not be separately authorized. Likewise, where staff delivering this service on a given day conclude this service at the person's home, transportation of the person *from* this service is not necessary and shall not be separately authorized.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
- If a person is successfully employed in individualized, integrated employment, services may be used to explore advancement opportunities in his or her chosen career, if such services are not otherwise available to the individual through ADRS.

- The state allows individuals to receive both Ticket to Work Outcome payments and Medicaid employment support services. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
    - Payments that are passed through to users of supported employment services; or
    - Payments for training that is not directly related to a person's supported employment program.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Job Developer	None	See Other.	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
Job Coach	None	See Other.	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider Agency	None	DDD Provider Certification	<u>The Agency:</u> • Employs a program manager who will supervise DSP's providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

3. **Co-Worker Supports -** This service involves the DDD-certified provider of this service (who receives a monthly service fee for their ongoing oversight and involvement) entering into an agreement with the employer to reimburse the employer who will in turn reimburse one or more co-workers and/or supervisors, agreeable to the person supported, for supports in lieu of a Job Coach.

This service can be considered at any time the individual wishes to have Co-Worker Supports rather than Job Coaching, given that Co-Worker Supports are less intrusive and expected to be less costly to implement than Job Coaching (as per written agreement outlined below). This service can be used when an employer wants to hire an individual; but has reasons for not wanting an external job coach in the workplace. This service must be considered as an option with the individual and his/her employer if fading of Job Coaching has ceased to continue for at least six (6) months. The use of this service should also be authorized on a time limited basis (i.e., no more than 180 calendar days) and reviewed to determine need for renewal/continuation. This service cannot include payment for the supervisory and co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The co-worker(s) and/or supervisor(s) identified to provide the support to the person must meet the minimum qualifications (e.g., training, background checks, etc.) established for this service. The DDD-certified provider is responsible for oversight and monitoring of paid Co-Worker Supports and may verify correct provision of the service via reviews of documentation and billing specified in the written agreement required below, as well as via intermittent on-site monitoring.

The actual amount of Co-Worker Supports authorized is based on individual need as determined through an on-the-job support assessment the format for which is prescribed by DMH/DDD and as outlined in a Co-Worker Supports Agreement using a template prescribed by DMH/DDD and jointly signed by the person, the DDD-certified provider and the employer.

The DDD-certified provider must ensure the following as part of utilizing Co-Worker Supports:

- A formal written agreement is in place outlining the nature and amount of the supports, above and beyond natural supports, to be provided to the member by the employer, the amount of time necessary for the supervisor(s) or co-worker(s) to provide this support and the cost to the employer for this support, which will be reimbursed by the provider. The agreement should include expectations regarding documentation and billing necessary for the employer to be reimbursed by the provider.
- The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must pass background checks otherwise required for Job Coach. The DDD-certified provider is responsible for ensuring these checks are done (by the employer or provider) and for retaining copies of background check results on file.
- The DDD-certified provider conducts an orientation training to the supervisor(s) and/or co-worker(s) identified to provide the support to the individual. Full details of the training requirements can be found on the ADMH website (https://mh.alabama.gov/community-waiver-program/).
- The DDD-certified provider is available to provide back-up supports and/or additional training/technical assistance for the employer and member whenever this may be needed;
- The DDD-certified provider completes minimum monthly check-ins with the employer and the member.

- The Section 1115 Group 5 will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely

available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any Section 1115 Group 5 services. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment - Small Group, and/or Community Integration Connections and Skills Training.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
- The state allows individuals to receive both Ticket to Work Outcome payments and Medicaid employment support services. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
    - Payments that are passed through to users of supported employment services; or
    - Payments for training that is not directly related to a person's supported employment program.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Co-Worker or Supervisor	None	None	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider	None	DDD Provider Certification	<u>The Agency:</u> • Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services • The Agency must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

4. **Supported Employment – Small Group -** A service providing employment services and training activities to support successful transition to individualized integrated employment or

self-employment, or to supplement such employment and/or self-employment when it is only part-time.

The service may include:

- Small group career planning and Exploration
- Small group Discovery classes/activities
- Other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment
- Employment in integrated business, industry and community settings

Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time.

The maximum group size for mobile crews and enclaves is four (4) people with disabilities working together while receiving this service. In the enclave model, a small group of people with disabilities (no more than four (4) people) is trained and supervised to work as a team among employees who do not have disabilities at the host company's work site.

In the mobile work crew model, a small crew of workers (including no more than four (4) persons with disabilities and ideally also including workers without disabilities who are not paid providers of this service) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community.

In each model, the Supported Employment—Small Group Supports provider is responsible for training, supervision, and support of participants.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals, as documented in their PCP. Supported Employment—Small Group Supports shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment.

Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the PCP must document that such opportunities are being provided through this service, to the person, on an on-going basis. The PCP shall also document and address any barriers to the person transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any person using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to

increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings. The settings must be integrated in and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment, engage in community life, and control their earned income.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- Paid work under Supported Employment—Small Group Supports must be compensated at minimum wage or higher.
- Supported Employment—Small Group Supports does not include vocational or Employment Path services, employment or training provided in facility-based work settings.
- Transportation of the person to and from this service is not included in the rate paid for this service; however transportation provided during the course of Supported Employment—Small Group Supports is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any Section 1115 Group 5 services. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, and/or Community Integration Connections and Skills Training.
- This service does not include support for volunteering.
- The Section 1115 Group 5 will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). ADRS does not provide small group supported employment services.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Job Coach	None	See Other.	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen

			• TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
DDD Certified Provider Agency	None	DDD Provider Certification	<u>The Agency:</u> • Employs a program manager who will supervise DSP's providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator</u>: • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this

			link: (https://mh.alabama.gov/community-waiver-program)

5. **Integrated Employment Path Services** - The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.

   Persons receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCP as the goal that Integrated Employment Path Services are specifically authorized to address.

   Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's specific individualized integrated employment and/or self-employment goals and career goals. If such specific goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

   The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment, including (but not limited to):
   - Ability to communicate effectively with supervisors, co-workers and customers;
   - Generally accepted community workplace conduct and dress;

- Ability to follow directions;
- Ability to attend to tasks;
- Workplace problem solving skills and strategies; and
- General workplace safety and mobility training.

- This service is limited to no more than one year. One extension of up to one year can be allowed only if the person is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e. ADRS Individualized Plan for Employment in place or Job Development funded by the 1115 Group 5) is concurrently authorized for this purpose. The one-year extension may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.
- Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for individualized integrated employment or self-employment), Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.
- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service will not duplicate other services provided through Medicaid Section 1115 Group 5 plan services and may not be billed for during the same period of time (e.g., the same hour) as other such services.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, and/or Community Integration Connections and Skills Training.
- The Section 1115 Group 5 will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Job Coach	None	See Other.	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense

			• Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider Agency	None	DDD Provider Certification	<u>The Agency:</u>
			• Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services
			• Must be Certified Community Provider in good standing with DDD including:
			  o No placement on Provisional status within the past 24 months; and
			  o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past
			
			<u>The Executive Director/owner/operator:</u>
			• Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse
			• Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable
			• Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings

			In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

6. **Financial Literacy and Work Incentives Benefits Counseling -** This service may include Financial Literacy and/or Work Incentive Benefits Counseling as appropriate to the needs of the person. The specific service authorization and corresponding billing code designates the focus of this service which must be consistent with the needs of the participant as outlined in the person-centered service plan.

   Financial Literacy services are specifically intended to:
   - Enable the person to improve his/her economic self-sufficiency necessary to continue to maintain his/her ability to sustain community living
   - Assist the person with evaluating his/her financial health and current level of financial literacy, and making a plan with specific strategies to improve his/her financial health and increase his/her level of financial literacy
   - Teach the person financial literacy skills and strategies
   - Assist the person to access community resources available to the person that address improvement of economic self-sufficiency and the person's financial health, including ability to sustain the independent/supported living arrangement

   Work Incentive Benefits Counseling is designed to:
   - Provide general introductory education that identifies and explains the multiple pathways to ensuring individualized integrated competitive employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This general introductory education should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated competitive employment. (When this service is authorized, if individual is previously or currently receiving Supported Employment-Individual Exploration Service, this service does not include general introductory education but does include the other service components listed here)
   - Provide a thorough Work Incentive Benefits Analysis addressing the benefits, entitlements, subsidies and services the individual receives to assess the impact that income from employment may have on continued eligibility and benefit amounts, including health coverage. Individuals are informed of work incentives, provisions that are designed to help protect benefits while working (i.e. Impairment Related Work Expense (IRWE), Earned Income Exclusion, PASS, Continued Medicaid and Extended Medicare, as well as other benefit programs for which the individual may be eligible. The information is intended to assist the person in making informed decisions about how much they can work and earn through individualized integrated competitive employment
   - Both the general introductory education service and the Work Incentive Benefits Analysis must provide education and information on the income reporting requirements for public benefit programs, including the Social Security Administration
   - This service may also include assistance with the submission of a PASS Plan or IRWE to the Social Security Administration depending on the needs of the individual.

- For Work Incentive Benefits Counseling, in addition to ensuring this service is not otherwise available to the individual within ninety (90) calendar days under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), the Section 1115 Group 5 may not fund this service if Community Work Incentives Coordinator Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.
- Introductory general education as part of Work Incentive Benefits Counseling shall be limited to individuals ages 22-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of four (4) hours of face-to-face service. This component of service can be reauthorized once per Section 1115 Group 5 year. This aspect of service cannot be authorized for this purpose if person previously or currently receiving Supported Employment-Individual Exploration Service).
- Work Incentive Benefits Analysis, as part of Work Incentive Benefits Counseling, shall be limited to individuals ages 22--60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of twenty-three (23) hours of service covering all necessary steps for production of a Work Incentive Benefits Analysis report. This component of service may be authorized no more than once every three (3) years and only if circumstances have significantly changed since the prior authorization, warranting a new analysis.
- Assistance with development of a PASS Plan or IRWE is limited to a total of fifteen (15) hours of service covering all necessary steps involved for submission to, and approval by, the Social Security Administration. This component of service may not be authorized more than once every three (3) years and only if the person's circumstances warrant this and Social Security Administration approval is likely.
- PRN Problem-Solving services for someone to maintain individualized integrated competitive employment: up to four (4) hours per situation requiring PRN assistance. This service may be authorized up to three (3) times per year if necessary for the individual to maintain individualized integrated competitive employment.
- The service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation and/or interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Financial Literacy Counselor	None	See Other.	• Minimum of Associates Degree in human service or related field • For Work Incentives Benefits Counseling: ○ Must be a certified Community Work Incentives Coordinator (CWIC) or Work Incentives Practitioner (WIP) • Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of

			violence, abuse, neglect, exploitation or any felony offense In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider	None	DDD Provider Certification	<u>The Agency:</u>
			• Must be Certified Community Provider in good standing with DDD including:
			  ○ No placement on Provisional status within the past 24 months; and
			  ○ No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past
			
			<u>The Executive Director/owner/operator:</u>
			• Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse
			• Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable
			• Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings
			
			In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

7. **Community Transportation** - Transportation services offered in order to enable an individual to access the broader community, including competitive integrated workplaces, opportunities for integrated community participation, involvement and contribution, and community services, resources and businesses specified in the PCP. These services allow people to engage in typical day-to-day (non-medical) integrated community opportunities and activities such as going to and

from paid, competitive, integrated employment, stores, bank, social opportunities with other members of the broader community, social events, clubs and associations, other community activities, and attending a worship service when public or other community-based transportation services or transportation provided by natural supports are not available. As part of the service, a natural or paid support-giver may accompany the person using Community Transportation, if the need for such supports are necessary and documented in the PCP.

- This service never replaces natural supports available to the Section 1115 Group 5 participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time. Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide this assistance without charge.
- The planning team must ensure the most cost-effective means of transportation is utilized, while still assuring provision of reliable transportation when a Section 1115 Group 5 participant needs this transportation to access non-medical opportunities in the community.
- Actual costs (based on established reimbursement per mile of travel) for this travel via a stand-alone transportation service provider must be calculated prior to authorization of the service and must not exceed the established maximum set in policy by DMH/DDD.
- If this service is not self-directed, this service is limited to 250 miles per month, except if used for individualized competitive integrated employment in which case limited to actual miles to/from individualized competitive integrated employment plus 120 miles per month.
- If this service is self-directed, this service is authorized as a monthly budget amount. The Financial Management Service Agency (FMSA) will only pay for transportation costs in the self-directed individual's PCP. Carry-over of unused amounts is limited to 25% and can be carried over for up to three (3) months.
- This service is not available when another covered service is being provided and transportation to/from and/or during the service is a component part of this covered service. SC monitoring will review provision of the service to ensure no duplication of transportation components of services provided.
- Transportation for attending medical appointments is covered under Non-Emergency Medical Transportation and not included in this service. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which shall not be supplanted, and which includes transportation to medical appointments as well as emergency medical transportation.
- This service may not be used for transportation between the waiver participant's home and a provider owned or controlled residential or non-residential setting.
- An individual community transportation provider (e.g., a self-direction worker) can provide this service on a fee-for-service reimbursement basis (e.g., per mileage or per one-way/round trip).

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Individual Community Transportation Provider	Valid Alabama Driver's License		• Liability Insurance • Minimum age of 18 • Must pass a statewide background check confirming no convictions for

			any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
DDD Certified Provider		Certification by ADMH/DDD	<u>The Agency:</u> • Liability insurance • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past. <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and

			developmental disabilities in community settings. In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
Transportation Company	License/permit, as applicable, from the Alabama Public Service Commission and any local authorities	Certificate to operate, as applicable, from the Alabama Public Service Commission and any local authorities	• Stand-alone transportation companies must comply with the Alabama Motor Carrier Act and must be certified or be issued a permit to operate, as applicable, by the Alabama Public Service Commission. In addition, they must adhere to any local certification or licensure requirements.

8. **Independent Living Skills Training -** Time-limited, focused service that provides targeted education and training for specific skill development to enable the Section 1115 Group 5 participant to develop ability to independently perform routine daily activities at home as specified in the person's PCP. Services are not intended to provide substitute task performance

by staff. Services are instructional and training-oriented, focused on development of skills identified in the PCP.

Independent Living Skills Training may include only education and training for skill development related to:

- Personal hygiene, self-care skills and routines
- Food and meal preparation, including menu planning
- Home upkeep/maintenance including outdoor upkeep/maintenance as applicable
- Money management including skills for controlling and safeguarding personal financial resources at home
- Home-based communication device use (e.g. computer/phone/cell phone)
- Skills for personal safety at home
- Parenting skills (if minor children of Section 1115 Group 5 participant residing with Section 1115 Group 5 participant)

Independent Living Skills Training is intended as a short-term service designed to allow a person to acquire specific skills for independence in defined tasks and activities for community living. Goals for skill development and independence at home must be age-appropriate for the Section 1115 Group 5 participant. The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the PCP. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a Section 1115 Group 5 participant.

Because home-based skills are being taught, parents and/or other natural supports in the home will be encouraged to observe the training so they can learn how to use the instructional strategies, reinforce the learned skills and contribute to ensuring the maintenance of these skills after the service ends.

The provider must document weekly progress toward achieving each independent living skill identified in the PCP. The provider is expected to provide this service in the person's own home where the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

- The service amount, duration, and scope must be documented in the PCP.
- This service may be authorized for a maximum of 10 hours/week (no more than 2 hours/day) but shall be appropriate to the goal for authorizing the service and the person's existing level of skill (gap between existing level of skill and goal) prior to the service being authorized;
- Once a Section 1115 Group 5 participant has achieved the ability to independently perform specific routine daily activities, this service may only be authorized to address a *different* routine daily activity (e.g., the above service limitations are enforced per skill identified as in need of training as specified in the person's PCP), or authorized, if needed, only very intermittently and for minimal time, to focus on sustaining skills for independence already achieved so these are not lost.

Provider Qualifications			
Provider Type	License	Certification	Other Standard

Independent Living Skills Trainer	None	None	• Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities • An Associate's degree from an accredited institution in a human services field is preferable but not required • Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider	None	DDD Provider Certification	<u>The Agency:</u> • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

9. Community Integration Connections and Skills Training - This service occurs over a defined period of time, aligned with a specific service delivery plan and timeline for achieving one or more outcomes related to a Section 1115 Group 5 participant's needs as specified in the PCP. The service connects the participant with integrated opportunities for the person to achieve his/her unique goals for community participation, involvement, membership, contribution and connections, and when needed, includes targeted education and training for specific skill development to enable the participant to develop ability to independently (or with natural supports only) engage in these integrated opportunities as specified in the person's PCP.

This service focuses specifically on successful participation in community opportunities that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service also focuses on ensuring the ongoing interactions with members of the

broader community are meaningful and positive, leading to the development of a broader network of natural supports for the individual.

The community connections component of this service is focused on assisting the person to find and become engaged in specific opportunities for community participation, involvement, membership, contribution and connections.

The service focus on community connections includes the following:

- Connections to members of the broader community who share like interests and/or goals for community participation, involvement, membership and/or contribution
- Connections to community organizations and clubs to increase the individual's opportunity to expand community involvement and relationships consistent with his/her unique goals for community involvement and expanded natural support networks, as documented in the PCP
- Connections to formal/informal community associations and/or neighborhood groups
- Community classes or other learning opportunities related to developing passions, interests, hobbies and further mastery of existing knowledge/skills related to these passions, interests and hobbies
- Connections to community members, opportunities and venues that support an individual's goals related to personal health and wellness (e.g. yoga class, walking group, etc.)
- Connections to volunteer opportunities focused primarily on community contribution rather than preparation for employment

The provider must document weekly progress toward achieving each goal for community participation, involvement, membership, contribution and connections for which the service is specifically authorized and which is documented in the PCP.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve their personally identified goals for community participation, involvement, membership, contribution and connections, including developing and sustaining a network of positive natural supports. The provider is expected to provide this service in the appropriate integrated community setting(s) where the opportunities take place and the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

The skills training component of this service is instructional and training-oriented, and not intended to provide substitute task performance by staff. Skill training is focused on the development of skills identified in the PCP that will enable the person to continue participation in integrated community opportunities without 1115 Group 5-funded supports.

Community Integration Connections and Skills Training may include only education and training for skill development related to:

- Developing and maintaining positive reciprocal relationships with members of the broader community who are not other Section 1115 Group 5 participants, paid staff or family members
- Participation in community activities, clubs, formal or informal membership groups and other opportunities for community involvement, participation and contribution (all so long as the activity clearly meets a goal(s) designated in the PCP)

- Accessing and using community services and resources available to the general public
- Safeguarding personal financial resources in the community
- Mobility training and travel training
- Cell phone and/or personal emergency response services (PERS) use in the community
- Skills for personal safety in the community

The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the PCP. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a Section 1115 Group 5 participant. The provider must document weekly progress toward achieving each goal for community integration skill development and independence identified in the PCP.

- All settings where Community Integration Connections and Skills Training is provided must meet all HCBS Settings Rule standards and cannot be provider owned or controlled.
- The service amount, duration, and scope must be documented in the PCP.
- This service is provided separate and apart from the person's private (including family) residence, other residential living arrangement and/or the home of a service provider and is not provided in provider owned or controlled facilities.
- One expected result of this service is fading of the service and less dependence on paid support over time in favor of increased natural supports and skills for community involvement and participation;
- This service should be authorized only for the period of time necessary for the participant to achieve the goals of the service which include facilitating one or more community connections and/or to facilitating acquisition or mastery of one or more skills for participation in integrated community opportunities and relationships.
- Although this service is a discrete service unto itself, it is intended to be a "wrap-around" support to participation in individualized, competitive integrated employment, Supported Employment-Small Group services and/or Integrated Employment Path Services, or is intended for individuals of retirement age (65+) who have elected not to pursue further employment opportunities, or for individuals who, after participating in the informed choice process available through completion of the Exploration service, have decided not to pursue individualized, competitive integrated employment at this time.
- This service does not provide actual membership fees or class tuition unless for a documented specific need in the PCP that is most effectively/efficiently met through the fee payment and that helps the individual remain living in the community.
- Staff-to-person ratios may vary from 1:1 to 1:3, with variable payment based on the specific ratio.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any Section 1115 Group 5 services.
    - It is the responsibility of the SC to monitor and ensure compliance with these service limits.

- The specific hours per week allowable to a person, and their associated employment status, will be documented in the PCP and will be verified during SC monitoring of the service's delivery.
- Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, and/or Community Integration Connections and Skills Training.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Community Integration Worker	None	None	• Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities • An Associate's degree from an accredited institution in a human services field is preferable but not required • Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
DDD Certified Provider	None	DDD Provider Certification	<u>The Agency:</u> • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past. <u>The Executive Director/owner/operator:</u>

			• Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

10. **Peer Specialist Services -** A service that assists a person to develop and utilize skills and knowledge for self-determination in one or more of the following areas:
    - Directing the person-centered planning (PCP) process
    - Understanding and considering self-direction
    - Understanding and considering individualized integrated employment/self-employment; and
    - Understanding and considering independent and supported living community living options.

    The service is provided on a time-limited basis, determined by the person's individual need, by a peer with intellectual or developmental disabilities who has experience matched to the focus area, needs and goals of the person receiving this service: has successfully directed their own Person-Centered Planning process; has self-directed their own services; has successfully obtained individualized integrated employment at a competitive wage; and/or utilizes independent/supported living options.

    A qualified Peer Specialist service provider understands, empathizes with the person while working to empower the person, supporting three critical areas important for enhancing self-esteem and self-determination:
    - The human need for connections, social supports and allies;
    - Overcoming the disabling power of learned helplessness, low expectations, and the stigma of labels; and
    - Supporting self-advocacy, informed choice and dignity of risk in decision making.

    <u>The Peer Specialist service provider offers:</u>
    - Education and training on the principles of self-determination, informed decision making and informed risk-taking

- One-on-one training, information and targeted support to encourage and support the person to lead their own Person-Centered Planning process, pursue self-direction, seek individualized, integrated competitive employment and/or pursue independent living/supported living options in the community
- Education on self-direction, including best practices recruiting, hiring and supervising staff
- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing individualized, integrated competitive employment
- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing independent/supported living opportunities, including selection of place to live and, if needed or desired, housemates; and
- Assistance with identifying opportunities for increasing natural allies a person has to rely on, including opportunities for the development of valued social relationships, and expanding unpaid sources of support in addition to, or reduce reliance on, paid services.

- These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an indefinite basis, nor should these services be provided for companionship purposes only.
- The focus of these services should be customized to the specific goal(s) of the person receiving these services.
- Transportation of the person receiving this service is not included in the rate or in the scope of expectations for the Peer Specialist.
- The SC is responsible for monitoring the satisfaction of the person served and outcomes resulting from this service on a monthly basis and documenting these things in the person's record.
- Medicaid does not pay for the initial training required to become a paid provider of Peer Specialist Supports.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Peer Specialist	None	None	• Must have successfully directed their own Person-Centered Planning process and self-directed their own services for a minimum of one (1) year • Must have successfully obtained individualized integrated employment at a competitive wage, and/or utilizes independent/supported living options • Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency

			In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

DDD Certified Provider	None	DDD Provider Certification	<u>The Agency:</u>
			• Must be Certified Community Provider in good standing with DDD including:
			  o No placement on Provisional status within the past 24 months; and
			  o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past.
			
			<u>The Executive Director/owner/operator</u>:
			• Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse
			• Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable
			• Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings
			
			In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

11. Assistive Technology and Adaptive Aids - An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in their home, in community participation, and in competitive integrated employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform activities of daily living or instrumental activities of daily living independently or more cost effectively than would be possible otherwise. This service must include strategies for training the individual,

natural/unpaid and paid supporters of the individual in the setting(s) where the technology and/or aids will be used, as identified in the PCP.

Assistive Technology and Adaptive Aids covers the following:

- Evaluation and assessment of the Assistive Technology and Adaptive Aids needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments where the person is expected to use the specific technology or equipment, including the home, integrated employment setting(s) and integrated community locations;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;
- Adaptive equipment to enable the individual to complete activities of daily living or instrumental activities of daily living independently or to do so in a way that either allows natural supports to provide the human assistance still needed or allows the cost of paid supports otherwise needed to be reduced to offset the cost of the technology or aid within one (1) year. Such assistive technology or adaptive equipment includes:
    - Adaptive switches and attachments;
    - Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes.
    - Adaptive toileting equipment;
    - Communication devices and aids that enable the person to perceive, control or communicate with the environment, including augmentative communication devices;
    - Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and teletouch systems, and long white canes with appropriate tips to identify footpath information for people with visual impairment);
    - Adaptive computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace (unless eligible as a reasonable accommodation by the employer) and in the community;
    - Software, when required to operate accessories included for environmental control;
    - Pre-paid, pre-programmed cellular phones that allow an individual, who is participating in employment or community integration activities without paid or natural supports and who may need assistance from remote sources of support or due to an accident, injury or inability to find the way home, to access such assistance independently. The person's PCP outlines the protocol that is followed for training, regular practice in using and regular checks of operability for a cellular phone including plan for when the individual may have an urgent need to request help while in the community;
    - Such other durable and non-durable medical equipment not available under any other part of the state Medicaid plan that is necessary to address functional limitations in the community, in the workplace, and in the home.

- Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the Assistive Technology and Adaptive Aids.
- Repairs of equipment and items purchased through this Section 1115 Group 5 program or purchased prior to participation in this program, as long as the item is identified within this service definition, and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

- Items reimbursed with Section 1115 Group 5 funds shall be non-duplicative of, and to meet an assessed need(s) in addition to, any medical equipment and supplies available to the individual and furnished under any other part of the state Medicaid plan. Repairs of items purchased under any other part of the state Medicaid plan shall be covered by the state Medicaid plan.
- Items reimbursed with Section 1115 Group 5 funds shall exclude those items which are not of direct medical or remedial benefit to the recipient.
- All items must meet applicable standards of manufacture, design and installation.
- A written recommendation by an appropriate professional (most typically, the professional that completed the evaluation and assessment or a prescription from a physician) must be obtained to ensure that the equipment will meet the needs of the person. For Assistive Technology and Adaptive Aids in the workplace, the recommendation of the Alabama Department of Rehabilitative Services/Vocational Rehabilitation (ADRS/VR) can also meet the requirement of a written, professional recommendation.
- The provision of this service to support the person in competitive integrated employment is only available for an individual who is working in competitive integrated employment and only if what is needed is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Persons interested in <u>obtaining</u> competitive integrated employment should be referred to ADRS/VR, and the need for assistive technology and/or adaptive aids will assessed and identified in the ADRS/VR process.

  Depending upon the financial size of the employer or the employer's status as a public entity, these employers may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Authorized Equipment Vendor	• Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.		

12. Remote Supports - The provision of supports to a Section 1115 Group 5 participant at their place of residence by Remote Support staff housed at a remote location and who are engaged with the person through equipment with the capability for live, two-way communication. Remote Supports shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using the appropriate stable, reliable connection. While Remote Supports are being provided, the remote support staff shall not have duties other than remote support.

Equipment used to meet this requirement may include but is not limited to one or more of the following components:

- Sensor Based System (e.g. motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.)
- Radio frequency identification;
- Live video feed;
- Live audio feed;
- Web-based monitoring system;
- Another device that facilitates live two-way communication;
- Contact ID

Remote Supports are provided pursuant to the PCP and required protocol(s) that are developed from, and support implementation of, the PCP. Remote Supports are intended to address a person's assessed needs in his/her residence, and are to be provided in a manner that promotes autonomy and minimizes dependence on paid support staff. Remote Supports should be explored prior to authorizing services that may be more intrusive. A person's team, including the person themselves, shall assess whether Remote Support is appropriate and sufficient to ensure the person's health and welfare assuming all appropriate protocols are in place to minimize risk as compared to the overall benefit of Remote Supports for the individual.

A backup support person is always identified, available and responsible for responding to the site of the person's residence whenever the person otherwise needs in-person assistance, including emergencies. Backup support may be provided on an unpaid basis by a family member, neighbor, friend, or other person selected by the individual, or on a paid basis by a local provider of Section 1115 Group 5 services. When backup support is provided on a paid basis by a local provider, that provider shall be the primary contact for the Remote Support vendor.

The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the backup support person(s) to provide assistance when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off. When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP but no longer than one (1) hour) when a request for in-person assistance is made.

If a known or reported emergency involving a person arises, the Remote Support staff shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the backup support person. The Remote Support staff shall stay engaged with the person during an emergency, as appropriate to the situation, until emergency personnel or the backup support person arrives.

The Remote Supports vendor shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring base system and have training on the most recent versions of the written protocols for each person supported. The Remote Supports vendor shall ensure a suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP.

The Remote Supports vendor shall have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages. The Remote Supports vendor shall have other backup systems and additional safeguards in place which shall include, but are not limited to, contacting the backup support person in the event the monitoring base system stops working for any reason. The Remote Supports vendor shall comply with all federal, state, and local regulations that apply to the operation of its business or trade, including but not limited to, 18 U.S.C. section 2510 to section 2522 as in effect on the effective date of this rule. The Remote Supports vendor shall have an effective system for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

- Remote Supports shall only be provided in Section 1115 Group 5 participants' places of residence when paid or unpaid sources of support are not present in the residence, except temporarily, if needed, when the Remote Supports are being initially introduced. In Supported Living or Community-Based Residential settings, the reimbursement rate to the provider shall be adjusted to account for the use of Remote Supports and the provider's role in providing backup support for the Section 1115 Group 5 participant(s) in the residence.
- Camera systems are located in communal areas of the home where the individual is likely to spend time and not places where an individual may wish to go to gain privacy (e.g., bathroom or bedroom). Systems are customizable and can be located wherever the individual prefers.
- When Remote Supports involve the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the person who receives the service and each person who lives with the person shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person or a person who lives with the person has a guardian, the guardian shall consent in writing. The person's service and support administrator shall keep a copy of each signed consent form with the PCP.
- A monitoring base shall not be located at the residence of a person who receives Remote Supports.

- A secure network system requiring authentication, authorization, and encryption of data that complies with applicable state laws currently in effect shall be in place to ensure that access to computer, video, audio, sensor, and written information is limited to authorized persons.
- If a Reportable Event as defined in the DDD Critical Incident Prevention and Management System occurs while a person is being monitored, the Remote Supports provider shall retain, or ensure the retention of, any video and/ or audio recordings and any sensor and written information pertaining to the incident for at least seven years from the date of the incident.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize use of this service in the home of a Section 1115 Group 5 participant(s) living with family as a cost-effective alternative to other medically necessary covered benefits, transition to an enrollment group with a higher expenditure cap, or to avoid institutional placement. Reauthorization is possible with re-assessment and CSD and DDD central office approval.
- All residents of a home where Remote Supports are provided must give advance, informed consent to being subject to the remote monitoring apparatus, as must anyone who later joins the residence. In addition, there must be a protocol (e.g., a written sign, etc.) for informing visitors to the residence that they might be recorded.
- The person receiving Remote Supports will be trained on the option of turning the monitoring equipment off for periods of time, if desired, and on turning it back on.
- When a person receives Remote Supports with paid backup support, the Remote Supports provider shall bill for the Remote Supports and provide the remote support directly or through a contract with a Remote Supports vendor that meets the requirements of this rule. In the event that the remote support staff contact the Remote Supports provider to request emergency or in-person assistance, the paid backup support person's time shall be billed as Personal Assistance or Self-Directed Personal Assistance, as applicable.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Back-Up Support Worker	None	None	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen • TB skin test as required by Alabama Medicaid Agency In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
Paid Back-Up Support Provider	None	DDD Provider Certification	<u>The Agency:</u> • Must be Certified Community Provider in good standing with DDD including:

			○ No placement on Provisional status within the past 24 months; and ○ No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator</u>: • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
Technology Installer & Provider	As applicable to federal, state and local statutes	As applicable to federal, state and local statutes	• Recognized and experienced vendor or Remote Supports technology with experience in at least two (2) other states and current capability to provide Remote Supports services in geographic areas covered by this Section 1115 Group 5 in State of Alabama.

13. **Housing Counseling Services -** Services which provide assistance to a person when acquiring housing in the community, where ownership or rental of housing is separate from service provision and where the person is directly responsible for the housing cost. The purpose of Housing Counseling Services is to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the individual, and promotes community inclusion.

<u>Housing Counseling Services include counseling and assistance to the individual, based on individual needs and a plan reflecting these needs, in the following areas:</u>

- Exploring both home ownership and rental options
- Exploring both individual and shared housing situations
- Identifying financial resources and determining affordability
- Identifying how earned income, or an increase in earned income, could impact choice, access and affordability of housing options
- Identifying preferences of location and type of housing
- Identifying accessibility and modification needs
- Locating available housing by educating and supporting the person to learn how to search for available housing and assist the individual in conducting housing searches
- Identifying and assisting with access to financing if homeownership is goal
- Identifying and assistant with access to rental subsidies if renting is goal
- Educating the person on the rights and responsibilities of a tenant, including how to ask for reasonable accommodations and modifications, how to request repairs and maintenance, and how to file a complaint if necessary; and
- Planning for ongoing management and maintenance if homeownership is goal.

Housing Counseling Services are time-limited services but are not one-time services and may be accessed more than once if an individual's needs dictates this.

Up to 50 hours/service depending on number and scope of outcomes the service is expected to achieve.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Housing Counselor	None	None	• Must have specialized training, certification and/or relevant experience in housing issues and how these impact people with disabilities • Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)
Certified DDD Provider	None	DDD Provider Certification	<u>The Agency:</u> • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12

			months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past <u>The Executive Director/owner/operator:</u> • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

14. Housing Start-Up Assistance - A service intended to provide essential services and items needed to establish an integrated community living arrangement for persons relocating from an institution or a provider owned or controlled residential setting. Housing Start-Up Assistance is intended to enable the person to establish an independent or supported living arrangement in which they are personally responsible for payment of rent/mortgage.

<u>Allowable costs include:</u>

- Deposit required for a leased or rented living arrangement
- Initial fees and/or deposits to establish utility service for water, heat, electricity, phone
- Purchase of basic and essential items needed to establish a safe and secure home:
  - External locks and keys
  - Smoke and carbon monoxide detectors
  - Fire extinguisher
  - Flashlight
  - First Aid Kit
- Moving costs

Housing Start-Up Assistance may also include person-specific services and supports that may be arranged, scheduled, contracted or purchased, which support the person's successful transition to a safe, accessible independent or supported living situation:

- Moving service

- Packing supplies
- Cleaning service
- Electronics set-up

No institutional length of stay requirement exists to access this service.

- Housing Start-up Assistance is only for the individual moving from either an institution or from a provider owned or controlled setting to a residence where the individual is responsible for his/her own housing costs (rent, utilities).
- Housing Start-Up Assistance costs in excess of $1,000 per person, not including deposit required for executing a lease/residency agreement, require prior approval from DMH/DDD central office for expenditures or purchases. Authorization of this service more than once every three (3) years requires prior approval from DMH/DDD central office.
- Services or items covered by this service may not be purchased more than 180 calendar days prior to the date the person relocates to the new independent/supported living arrangement.

Housing Start-Up Assistance services exclude:

- Purchase of food
- Payment of rent beyond advanced payment of a deposit required at the time of signing a lease or residency agreement;
- Purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service);
- Purchase of service agreements or extended warranties for appliances or home furnishings;
- Home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided via other sources
- Housekeeping services provided after occupancy which, if needed, may be provided through other sources or other Section 1115 Group 5 or Medicaid state plan services.

When this service is provided to an individual transitioning from a residential institution to a community-based independent/supported living setting, the service is not billed until the date the individual leaves the institution and begins Section 1115 Group 5 services.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
DDD Certified Provider	None	None	The Agency: • Must be Certified Community Provider in good standing with DDD including: o No placement on Provisional status within the past 24 months; and o No substantiated findings of abuse, neglect, mistreatment or exploitation within the agency within the past 12 months and no hires of persons with known substantiated findings of abuse, neglect, mistreatment or exploitation at any time in the past

			The Executive Director/owner/operator • Must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse • Must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable • Must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

15. **Individual Directed Goods and Services -** Individual Directed Goods and Services are services are available to only those participants self-directing services who are able to save funds through negotiation of worker's employment wages. Individual goods and services include services, equipment or supplies, for the Section 1115 Group 5 participant's use and benefit that are specified in the person's PCP and that are not otherwise provided to the individual through this Section 1115 Group 5 or through the Medicaid State Plan.

    Purchases through Individual Directed Goods and Services must address an identified goal/outcome and related need in the PCP, as specified in the PCP, (including improving or maintaining the participant's opportunities for full membership in the community and/or competitive integrated employment) and meet the following requirements:

    - The item or service will decrease the need for other Medicaid services and/or decrease dependency on paid support services; and/or
    - The item or service will promote inclusion in the community, including enhancing access to and involvement with the person's own family (i.e., will facilitate communication/interaction); and/or
    - The item or service will increase the Section 1115 Group 5 participant's independence, including improved cognitive, social or behavioral functioning, and development or maintenance of personal, social or physical skills for independence; and/or
    - The item or service will increase the Section 1115 Group 5 participant's health and safety in the home or in his/her community; and/or
    - The item or service will increase the Section 1115 Group 5 participant's ability to continue living in the community and avoid institutionalization. Upon enrollment in self-direction and whenever the individual's budget is reviewed and/or updated, the person may identify goods and services they wish to save for, and these will be included in the savings plan and in the

person's budget, and submitted to the FMSA. A copy of the savings plan will be kept in the person's record and maintained by the SC. Each month, the FMSA will be paid the proportional allotment specified in the savings plan and will follow their process of working with the individual on procurement and reimbursement, as well as adjusting the person's budget accordingly. The FMSA will notify the Regional Office, and the SC of the actual amount spent on Individual Directed Goods and Services monthly.

- The SC will be responsible for monitoring the balances of the savings to ensure proper utilization. The SC has oversight of expenditures of Individual Goods and Services and must document the need of any item or service in the case record. The DDD Fiscal staff will review the savings plan annually and verify accurate and appropriate use of savings, based on documentation of balances and expenditures by SCs and the FMSA, respectively.
- All purchases must be for items or services that are not illegal or otherwise prohibited by Federal and State statutes and regulations. All purchases can only be made if the participant does not have the funds to purchase the item or service and the item or service is not available at no cost to the participant through another source. All purchases must also be evaluated to ensure cost effectiveness as compared to other available uses of the savings account to meet the person's goals/outcomes and related needs and to assures health, safety, and welfare.
- Individual Directed Goods and Services are limited to those individuals self-directing services.
- The limit on amount of funds for purchases under Individual Directed Goods and Services is determined individually based on the balance of the individual's savings account at the time of the request for purchase. The savings account is maintained by the Financial Management Services Agency. The duration of this service is again based on the individual's savings account balance and the individual's participation in self-directed services. If an individual returns to traditional Section 1115 Group 5 services (stops self-directed any services) the ability to access any dollars from the savings account and utilize this service will be terminated. Additionally, dollars not utilized will be refunded to the Division of Developmental Disabilities.
- Dollars can be accumulated past the fiscal year, however, cannot exceed $10,000.00 at any given time.
- State plan services should be expended prior to the utilizing the Individual Goods and Services.
- Individual Goods and Services can be utilized in lieu of other Section 1115 Group 5 services in the event there are no providers available to the participant to provide a service that can otherwise be purchased through Individual Directed Goods and Services. This must be documented in the case record. (If a service is unavailable to a person due to lack of a provider in their area to administer said service, Individual Goods & Services may offer a reasonable alternative to the un-provided service, if possible)
- Items, goods or services that are not for the primary benefit of the participant are prohibited. Items, Goods and Services unrelated to the person's identified goals/outcomes and related assessed needs are prohibited.
- Experimental or prohibited treatments are excluded, as well as room and board, items solely for entertainment or recreation, cigarettes and alcohol.
- Purchase of goods or services that are illegal or otherwise prohibited by Federal and State statutes and regulations is prohibited.

Provider Qualifications			
Provider Type	License	Certification	Other Standard
Self-Directed Worker	N/A	N/A	• Minimum age of 18 • Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense • Must pass a pre-employment drug screen In addition to the qualifications above, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program)

Attachment F:
Quality Improvement System Performance Measures

Note: Quality Improvement System performance measure data will be collected and submitted as described in the 1915(c) Technical Guide.

Administrative Authority of the Single State Medicaid Agency

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 program***
- ***Equitable distribution of program openings in all geographic areas covered by the program***
- ***Compliance with HCB settings requirements and other new regulatory components***

Where possible, include numerator/denominator.

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

Performance Measure:	Percent of data reports specified in the agreements, policies and procedures with the Medicaid Agency that were submitted on time and in the correct format by the OA. Percentage = NUMERATOR [Number of data reports provided timely and in the correct format] / DENOMINATOR [Number of data reports due]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Reports to State Medicaid Agency on delegated Administrative functions, as documented in the AMA Program Manager Log			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of requested reports submitted by the OA reviewed and validated by the designated AMA Program Manager for program compliance. Percentage = NUMERATOR [Number of OA submitted reports reviewed and validated by the AMA Program Manager for program compliance] / DENOMINATOR [Number of reports submitted by the OA]
Data Source *(Select one) (Several options are listed in the on-line application):*	

If 'Other' is selected, specify:			
Quarterly and Ad Hoc Reports submitted by the OA, as documented in the AMA Program Manager Log			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*X Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of waiver / 1115 Group 5 program records reviewed by the Medicaid Agency that were compliant with program requirements. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 program records reviewed by the Medicaid Agency that were compliant with program requirements] / DENOMINATOR [Number of waiver / 1115 Group 5 program records reviewed by the Medicaid Agency]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Record Reviews, on-site; Record Reviews, off-site (AMA audit results)	

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

Data Aggregation and Analysis

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

☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Number and percent of total reported performance measures that were above 86%. Percentage = NUMERATOR [Number of reported performance measures that were above 86%] / DENOMINATOR [Number of reported performance measures]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Performance measure reporting tool			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	☐ *Representative Sample; Confidence Interval*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

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

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

FMSA Data

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

		Specify:		
				◻ *Other Specify:*

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

Performance Measure:	Number and percent of programmatic operating procedures pertaining to the waiver / 1115 Group 5 issued by the OA that were approved by AMA prior to being issued by the OA. Percentage = NUMERATOR [Number of programmatic operating procedures pertaining to the waiver / 1115 Group 5 issued by the OA that were approved by AMA prior to being issued by the OA] / DENOMINATOR [Number of programmatic operating procedures pertaining to the waiver / 1115 Group 5 issued by the OA]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
OA programmatic operating procedures submitted for review, as documented in the AMA Program Manager Log			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

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

Performance Measure:	1115 Group 5 participants reside in a family member or other natural caregiver's home, their own home, or in a leased unit they lease from a landlord that is not a provider of HCBS. Percentage = NUMERATOR [Number of enrolled 1115 Group 5 participants who reside in a family member or other natural caregiver's home, their own home, or in a leased unit they lease from a landlord that is not a provider of HCBS]/ DENOMINATOR [Number of enrolled 1115 Group 5 participants]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

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

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

Performance Measure:	Number and percent of 1115 Group 5 participants for whom all service settings are integrated in, and support full access to, the community. Percentage = NUMERATOR [Number of enrolled 1115 Group 5 participants for whom all service settings are integrated in, and support full access to, the community]/ DENOMINATOR [Number of enrolled 1115 Group 5 participants]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Case Manager Monitoring Reports

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

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

	X Continuously and Ongoing
	☐ Other Specify:

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

The Alabama Medicaid Agency has an established methodology for aggregating data from multiple sources and weighting it to rate performance within a specific domain. The methodology was designed through a collaborative effort between the AMA and consultants at Navigant.

b. Methods for Remediation/Fixing Individual Problems

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

All measures are shared with the operating agency in quarterly reports, and are presented with reference to baseline data from previous periods. The goal is to improve the scores, but if they stay the same or decrease slightly, it does not require corrective action. Significant drops from baseline, as determined by the Medicaid Agency, will require follow-up, and a plan of correction.

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)*
[redacted]	*X State Medicaid Agency*	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other Specify:	*X Annually*
		☐ Continuously and Ongoing

[redacted]		☐ *Other Specify:*

Quality Improvement:

Participant Access and Eligibility

i. 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.

<table>
<tr><td>Performance Measure:</td><td colspan="3">Number and percent of participants who have a level of care (LOC) evaluation / an Assessment of Need for the 1115 Group 5 eligibility completed prior to entry into the HCBS waiver / 1115 Group 5.

Percentage = NUMERATOR [Number of participants who have a level of care (LOC) evaluation / an Assessment of Need for 1115 Group 5 eligibility completed prior to entry into the HCBS waiver / 1115 Group 5]/ DENOMINATOR [Number of participants]</td></tr>
<tr><td colspan="4">Data Source (Select one) (Several options are listed in the on-line application):</td></tr>
<tr><td colspan="4">If 'Other' is selected, specify:</td></tr>
<tr><td colspan="4">Record reviews, off-site; HCBS application and enrollment data</td></tr>
<tr><td></td><td>Responsible Party for data collection/generation (check each that applies)</td><td>Frequency of data collection/generation (check each that applies)</td><td>Sampling Approach (check each that applies)</td></tr>
<tr><td></td><td>☐ State Medicaid Agency</td><td>☐ Weekly</td><td>X 100% Review</td></tr>
<tr><td></td><td>X Operating Agency</td><td>X Monthly</td><td>Less than 100% Review</td></tr>
<tr><td></td><td>☐ Sub-State Entity</td><td>☐ Quarterly</td><td>Representative Sample; Confidence Interval =</td></tr>
<tr><td></td><td>☐ Other</td><td>☐ Annually</td><td></td></tr>
</table>

	Specify:			
		X Continuously and Ongoing		*□ Stratified: Describe Group:*
		□ Other Specify:		
				□ Other Specify:

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed / an Assessment of Need for 1115 Group 5. Percentage = NUMERATOR: [Number of applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed / an Assessment of Need for 1115 Group 5 eligibility / DENOMINATOR [Number of applicants for whom there is reasonable indication that services may be needed in the future]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews, off-site; HCBS application and enrollment data			
	Responsible Party for data collection/generation	***Frequency of data collection/generation***	***Sampling Approach*** *(check each that applies)*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of level of care / initial Assessment of Need for 1115 Group 5 eligibility determinations where the LOC /1115 Group 5 instruments and processes were appropriately applied and according to the approved description in the approved waiver / 1115 Group 5 needs criteria. Percentage = NUMERATOR [Number of level of care / initial Assessment of Need for 1115 Group 5 eligibility determinations where the LOC /1115 Group 5 instruments and processes were appropriately applied and according to the approved description in the approved waiver / 1115 Group 5] / DENOMINATOR [Number of LOC / initial Assessment of Need for 1115 Group 5 eligibility determinations]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews, on-site / Initial Assessments of Need

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

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	*(check each that applies*
☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*☐ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems regarding performance of level of care evaluations and 1115 Group 5 evaluations of need are currently handled by Regional Office staff of the Operating Agency. Resolution of these problems involves, as appropriate, re-training, enhanced monitoring for a period of time, a performance improvement plan, corrective action plan or other appropriate action steps. There is no Medicaid funding paid for someone not in active status with the Medicaid Fiscal Agent as of the date of service and no individual will be enrolled without a LOC, so there is never an issue of payments made incorrectly.

The Regional Office has designated staff (QIDPs) trained and experienced in administering LOC instruments and who are trained on the strategies employed by the state to discover/identify problems/issues and trained to review all supporting documentation that feeds into the level of care evaluation. An assessment in the information system will capture review results. A report will aggregate the data results to reveal patterns where success is less than 86%. Intervention, in general, will consist of:

a. Bringing the data to the attention of the 310 Board staff and/or Support Coordinators responsible for the discovered areas of weakness.

b. When data shows consistent problems over two consecutive quarters, technical assistance / training will be provided at the point of weakness.

c. If no improvement is seen in the next quarter after the intervention, a performance improvement plan or corrective action plan will be required. The regional offices will

ensure that any designated QIDPs who do not demonstrate full competence following implementation of the corrective action plan will not be allowed to perform LOC evaluations thereafter, until and unless the QIDP can demonstrate full competence.

ii Remediation Data Aggregation

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

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	X Operating Agency	☐ *Monthly*
	☐ *Sub-State Entity*	*X Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

Records are maintained by the Operating Agency's Regional Offices.

Quality Improvement:
Qualified Providers

i. 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 percentage of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid, and any applicable requirements of state laws prior to service provision. Percentage = NUMERATOR [Number of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid and applicable requirements of state laws] / DENOMINATOR [All new contracted providers]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews on-site (Initial Certification Surveys)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
[redacted]	*X Operating Agency*	*X Monthly*	*☐ Less than 100% Review*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percentage of existing contracted providers that continued to meet licensure and/or certification standards, other standards established by Medicaid and any applicable requirements of state law. Percentage = NUMERATOR [Number of existing contracted providers that continued to meet licensure and/or certification standards and other

	standards established by Medicaid] / DENOMINATOR [Number of existing contracted providers]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews, on-site (Certification Surveys)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*X Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:
			Providers are reviewed and certified on a rolling schedule based on their one or two-year certification status. Following the schedule of certifications due, ADMH completes provider certification visits

				on a continuous and ongoing basis each month. For each provider reviewed during a month, 100% of training verification records are reviewed.

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	☐ *Annually*
	X Continuously and Ongoing
	☐ *Other Specify: 100% of provider training verification records are reviewed over a two year cycle.*

Performance Measure:	Number and percentage of non-licensed/non-certified providers that meet waiver / 1115 Group 5 requirements and any applicable requirements of state law.

	Percentage = NUMERATOR [Number of non-licensed/non-certified providers that met waiver / 1115 Group 5 compliance requirements] / DENOMINATOR [Number of non-licensed/non-certified providers]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Provider records on-site and off site			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	*X Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

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

Performance Measure:	Number and percentage of self-directed employees/staff that meet state and waiver/ 1115 Group 5 requirements. Percentage = NUMERATOR [Number of self -directed employees that meet state and waiver/ 1115 Group 5 requirements]/DENOMINATOR [Number of self-directed employees/staff]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
FMSA employee enrollment packet			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*X Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other Specify: FMSA	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*

		☐ *Other Specify:*		
				☐ *Other Specify:*

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

Performance Measure:	Number and percentage of providers that meet training requirements in accordance with state requirements and the approved waiver/ 1115 Group 5. Percentage = NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver / 1115 Group 5] / DENOMINATOR [Number of providers]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews, on-site (Training verification records)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	*X Monthly*	☐*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*
			Providers are reviewed and certified on a rolling schedule based on their one or two-year certification status. Following the schedule of certifications due, ADMH completes provider certification visits on a continuous and ongoing basis each month. For each provider reviewed during a month, 100% of training verification records are reviewed.

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	☐ *Annually*
	X Continuously and Ongoing
	☐ *Other Specify: 100% of provider training verification records are reviewed over a two year cycle.*

Performance Measure:	Number and percentage of enrolled self-directed employees who continue to meet waiver / 1115 Group 5 training requirements. Percentage = NUMERATOR [Number of currently enrolled self-directed employees that continue to meet waiver / 1115 Group 5 training requirements]/ DENOMINATOR [Number of currently enrolled self-directed employees]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews, on-site (Training verification records)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

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

Performance Measure:	Number and percentage of new self-directed employees that meet waiver / 1115 Group 5 training requirements Percentage = NUMERATOR [Number of new self-directed employees that meet waiver / 1115 Group 5 training requirements]/ DENOMINATOR [Number of new self-directed employees]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews, Off-site; Training verification records; New Employee Enrollment packet

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Provider agencies are certified initially for 12 months and then either annually or biennially, or placed on provisional status, depending on their survey score. A high score will result in a two-year certificate; a score between 80 and 89 will result in a one-year certificate; and a score below 80 will result in the agency being placed on provisional status.

Provisional status is a temporary condition which allows an agency to submit a plan of correction and, when approved, implement that plan. Provisional status may not exceed 60 days, and many such status conditions are set at 30 days or less. At the end of that period, a re-survey is conducted, with the expectation that the agency will at least score high enough to give them a one-year certificate. However, should the agency score less than 80 on the re-survey, the certification unit may recommend a second provisional status, which also may not exceed 60 days in length. A follow-up re-survey is conducted at the end of the second provisional period, and if the provider does not score at least an 80, a recommendation is forwarded to the Commissioner of the DMH to de-certify the provider agency.

In addition to the routine certification surveys, the Operating agency may also conduct for cause surveys, in response to concerns or complaints about treatment and care of participants. Frequently the result of a for-cause survey is that the agency gets put on provisional certification and is required to submit and implement a plan of correction.

During a process in which a provider agency is in provisional status, the Regional Offices and Advocacy Section of the operating agency provide increased monitoring and technical assistance. This is both to assure basic health and welfare of the individuals receiving services and to assist the provider agency in coming into compliance.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	X Operating Agency	☐ *Monthly*
	☐ *Sub-State Entity*	*X Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

Quality Improvement: Participant-Centered Planning and Service Delivery

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

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews on-site (Certification)

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of participants whose service plans address all of the participant's personal goals. Percentage = NUMERATOR [Number of participants who have all of the participant's personal goals addressed in the service plan] / DENOMINATOR [Number of participant service plans reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis

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

i. 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.

<table>
<tr><td>Performance Measure:</td><td colspan="3">Number and percent of participants whose needs changed and whose service plans were revised accordingly.

Percentage = NUMERATOR [Number of participants reviewed whose needs changed and whose service plans were revised accordingly] / DENOMINATOR [Number of participants reviewed whose needs changed]</td></tr>
<tr><td colspan="4">Data Source (Select one) (Several options are listed in the on-line application):</td></tr>
<tr><td colspan="4">If 'Other' is selected, specify:</td></tr>
<tr><td colspan="4">Participant record reviews [e.g., Assessment Forms and person-centered service plan (PCCP)</td></tr>
<tr><td></td><td>Responsible Party for data collection/generation (check each that applies)</td><td>Frequency of data collection/generation (check each that applies)</td><td>Sampling Approach (check each that applies)</td></tr>
<tr><td></td><td>☐ State Medicaid Agency</td><td>☐ Weekly</td><td>☐100% Review</td></tr>
<tr><td></td><td>X Operating Agency</td><td>X Monthly</td><td>X Less than 100% Review</td></tr>
<tr><td></td><td>☐ Sub-State Entity</td><td>X Quarterly</td><td>X Representative Sample; Confidence Interval =95% with a margin of error of +/- 5%</td></tr>
<tr><td></td><td>☐ Other Specify:</td><td>☐ Annually</td><td></td></tr>
</table>

		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of PCCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver / 1115 Group 5. Percentage = NUMERATOR [Number of PCCP's reviewed that include the required participant signature in the PCCP development process] DENOMINATOR [Number of plans reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant Record reviews on-site (Certification)	

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

Data Aggregation and Analysis

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

	☐ *Other Specify:*

Performance Measure:	Number and percent of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver / 1115 Group 5. Percentage = NUMERATOR [Number of participants reviewed whose service plans were reviewed with the participant according to the timeframes specified in the waiver] / DENOMINATOR [Number of participants reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record reviews on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ *Other Specify:*	*X Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	

				☐ *Other Specify:*

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of participants reviewed whose service plans are updated at least annually. Percentage = NUMERATOR [Number of participants reviewed whose service plans were updated at least annually] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant Record reviews on-site (Certification)	

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

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the amount specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the amount specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant Record reviews on-site (Certification); Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	*(check each that applies*
☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*☐ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the duration specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the duration specified in the service plan] / DENOMINATOR [Number of participants reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant Record reviews on-site (Certification); Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
[redacted]	*X Operating Agency*	*X Monthly*	*X Less than 100% Review*
[redacted]	*☐ Sub-State Entity*	*X Quarterly*	[redacted] *X Representative Sample; Confidence Interval =95%* with a

				margin of error of +/- 5%
	☐ *Other Specify:*	☐ *Annually*		
		X Continuously and Ongoing		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the type specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the type specified in the service plan] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	

If 'Other' is selected, specify:			
Participant Record reviews on-site (Certification); Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

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

Performance Measure:	Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the frequency specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the frequency specified in the service plan] / DENOMINATOR [Number of participants reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant Record reviews on-site (Certification); Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
[redacted]	*X Operating Agency*	*X Monthly*	*X Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	*X Quarterly*	[redacted] *X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
[redacted]	☐ *Other Specify:*	☐ *Annually*	[redacted]
		X Continuously and Ongoing	[redacted] ☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	[redacted]

				☐ *Other Specify:*

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the scope specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the scope specified in the service plan] / DENOMINATOR [Number of participants reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant Record reviews on-site (Certification); Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of participants that answered "yes, all services" to being able to choose or change what kind of services they received. Percentage = NUMERATOR [Number of participants that answered "yes, all services" to being able to choose or change what kind of services they received] / DENOMINATOR [Number of participants interviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant interviews, on-site (Certification)	

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

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	*(check each that applies*
☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*☐ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of participant records reviewed that have a signed freedom of choice form that specifies that choice was offered among services and providers. Percentage = NUMERATOR [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among services and providers] / DENOMINATOR [Number of participant records reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant record reviews, on-site (Certification: Freedom of Choice forms)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
[redacted]	*X Operating Agency*	*X Monthly*	*X Less than 100% Review*
[redacted]	*☐ Sub-State Entity*	*X Quarterly*	[redacted] *X Representative Sample;*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of service plans that document the waiver / 1115 Group 5 participant was offered and made a choice between traditional and self-directed care. Percentage = NUMERATOR [Number of service plans that document the waiver / 1115 Group 5 participant was offered and made a choice between

	traditional and self-directed care] / DENOMINATOR [Number of participant service plans reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant record reviews, on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐*Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ *Other Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Number and percent of participants interviewed who reported the receipt of all services in the service plan. Percentage = NUMERATOR [Number of participants interviewed who reported the receipt of all services in the service plan]/ DENOMINATOR [Number of participants interviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant interviews, on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*

		☐ *Other Specify:*		
				☐ *Other Specify:*

Data Aggregation and Analysis

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

b. Methods for Remediation/Fixing Individual Problems

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

Remediation of individual problems occurs when problems are discovered by the regional office in monitoring plans. All of the discovery measures previously listed are produced by this monitoring, and the report of monitoring also includes notation of follow-up actions needed. The measures of remediation actions needed and performed are included in the electronic aggregation and reporting system, and are listed below:

Remediation: Measure 1

The number and percent of reviews which required individual technical assistance.

Remediation: Measure 2
The number and percent of reviews which required agency wide technical assistance and training.

Remediation: Measure 3
The number and percent of reviews which required a Plan of Correction.

If there are any reviews which required a plan of correction but the plan was either not submitted, not acceptable or not implemented, follow-up action would consist of referral to a "for-cause" certification review. In addition, depending on what the specific deficits were, funding could be recouped.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **State Medicaid Agency**	☐ **Weekly**
	X Operating Agency	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		X Continuously and Ongoing
		☐ **Other** Specify:

Quality Improvement:
Health and Welfare

i. 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.

<table>
<tr><td>Performance Measure:</td><td colspan="3">Number and percent of abuse, neglect, exploitation, or unexpected death incidents reviewed/investigated within the required timeframe.

Percentage = NUMERATOR [Total number of abuse, neglect and exploitation or unexpected death incidents reviewed/investigated within the required timeframe] / DENOMINATOR [Number of abuse, neglect and exploitation or unexpected death incidents]</td></tr>
<tr><td colspan="4">Data Source (Select one) (Several options are listed in the on-line application):</td></tr>
<tr><td colspan="4">If ‘Other’ is selected, specify:</td></tr>
<tr><td colspan="4">ADMH Incident Prevention Management System (IPMS)</td></tr>
<tr><td></td><td>Responsible Party for data collection/generation (check each that applies)</td><td>Frequency of data collection/generation (check each that applies)</td><td>Sampling Approach (check each that applies)</td></tr>
<tr><td></td><td>☐ State Medicaid Agency</td><td>☐ Weekly</td><td>X 100% Review</td></tr>
<tr><td></td><td>X Operating Agency</td><td>X Monthly</td><td>☐ Less than 100% Review</td></tr>
<tr><td></td><td>☐ Sub-State Entity</td><td>☐ Quarterly</td><td>☐ Representative Sample; Confidence Interval =</td></tr>
<tr><td></td><td>☐ Other Specify:</td><td>☐ Annually</td><td></td></tr>
</table>

		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of closed cases of abuse/neglect/exploitation for which the OA verified that the investigation conducted by the provider was done in accordance with state policy. Percentage= NUMERATOR [Number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with state policy] DENOMINATOR [Number of closed cases of abuse/neglect/exploitation]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
ADMH Incident Prevention Management System (IPMS)	

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

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

Performance Measure:	Number and percent of suspected abuse, neglect and exploitation incidents and unexpected deaths referred to appropriate investigative entities, e.g., Adult Protective Services, Child Protective Services and/or law enforcement. Percentage = NUMERATOR [Number of suspected abuse, neglect and exploitation incidents and unexpected deaths referred to appropriate investigative entities, e.g., Adult Protective Services, Child Protective Services and/or law enforcement] / DENOMINATOR [Number of instances of suspected abuse, neglect and exploitation and unexpected deaths]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
ADMH Incident Prevention Management System (IPMS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
[redacted]	*X Operating Agency*	*☐ Monthly*	*☐ Less than 100% Review*
[redacted]	*☐ Sub-State Entity*	*☐ Quarterly*	[redacted] *☐ Representative Sample; Confidence Interval =*
[redacted]	*☐ Other Specify:*	*☐ Annually*	[redacted]
		X Continuously and Ongoing	[redacted] *☐ Stratified: Describe Group:*
		X Other Specify: Daily	[redacted]
			[redacted] *☐Other Specify:*
			[redacted] .

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

Performance Measure:	Number and percent of participant records reviewed that do not identify previously unreported incidents of abuse, neglect, mistreatment, exploitation and unexplained deaths. Percentage = NUMERATOR [Total number of participant records reviewed that do not identify unreported incidents of abuse, neglect, mistreatment, exploitation, and unexplained deaths] / DENOMINATOR [Number of participant records reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant record reviews, on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

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

Performance Measure:	Number and percent of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. Percentage = NUMERATOR [Number of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of providers]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews, on-site (Certification: Training verification forms)

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify: Daily	
			☐ Other Specify:
			Providers are reviewed and certified on a rolling schedule based on their one or two-year certification status.

				Following the schedule of certifications due, ADMH completes provider certification visits on a continuous and ongoing basis each month. For each provider reviewed during a month, 100% of training verification records are reviewed.

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐*State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify: 100% of provider training verification records are reviewed over a two year cycle.*

Performance Measure:	Number and percent of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. NUMERATOR [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of case managers]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews, on-site (Certification: Training verification forms)

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify: Daily	
			☐ Other Specify:
			Providers are reviewed and certified on a rolling schedule based on their one or two-year certification status.

				Following the schedule of certifications due, ADMH completes provider certification visits on a continuous and ongoing basis each month. For each provider reviewed during a month, 100% of training verification records are reviewed.

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐*State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify: 100% of provider training verification records are reviewed over a two year cycle.*

Performance Measure:	Number and percent of critical incidents that have been resolved by the ADMH within 60 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by the ADMH within 60 days of the date of the critical incident report date] / DENOMINATOR [Number of reported critical incidents]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
ADMH Incident Prevention Management System (IPMS)	

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

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

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

Performance Measure:	Number and percent of critical incident trends where systemic intervention was implemented. Percentage=NUMERATOR [Total number of critical incident trends where systemic intervention was implemented] / DENOMINATOR [Number of critical incident trends]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
ADMH Incident Prevention Management System (IPMS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*

		☐ *Other Specify:*		
				☐*Other Specify:*
				.

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

Performance Measure:	Number and percent of critical incident trends for which systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a corresponding revision to the intervention. Percentage=NUMERATOR [Total number of critical incident trends where systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a corresponding revision to the intervention] / DENOMINATOR [Number of critical incident trends for which systemic intervention was implemented]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
ADMH Incident Prevention Management System (IPMS)	

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

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

Performance Measure:	Number and percent of participants with restrictive interventions where proper procedures were followed. Percentage = NUMERATOR [Number of participants with restrictive interventions where proper procedures were followed] / DENOMINATOR [Number of participants who had a restrictive intervention applied]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

ADMH Incident Prevention Management System (IPMS)

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

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	*(check each that applies*
☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*☐ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of participant records reviewed that do not identify previously unreported incidents of unauthorized restrictive interventions or seclusion. Percentage = NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] / DENOMINATOR [Number of participant records reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant record reviews, on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval*

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

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

Performance Measure:	Number and percent of restraints approved in a behavior support plan that were applied three (3) times in a six-month (6) period and resulted in a team meeting to consider revision to the behavior plan as required by state policy. Percentage = NUMERATOR [Number of times restraints approved in a behavior support plan that were applied three (3) times in a six-month (6) period and resulted in a team meeting to consider revision to the behavior plan as required by state policy]/ DENOMINATOR [Number of times a

	restraint approved in a behavior support plan was applied 3 times within a six-month period]

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Participant record reviews, on-site (Certification)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*X Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95%* with a margin of error of +/- 5%
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐Other Specify:
			.

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

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

Performance Measure:	Number and percent of unapproved restrictive interventions that had a prevention plan developed as a result of the incident. Percentage = NUMERATOR [Number of unapproved restrictive interventions that had a prevention plan developed as a result of the incident]/ DENOMINATOR [Number of unapproved restrictive interventions]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
ADMH Incident Prevention Management System (IPMS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
[redacted]	*X Operating Agency*	*X Monthly*	☐ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ☐ *Representative Sample; Confidence Interval =*
[redacted]	☐ *Other Specify:*	☐ *Annually*	[redacted]
		X Continuously and Ongoing	[redacted] ☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	[redacted]

				☐*Other Specify:*
				.

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

Performance Measure:	Number and percent of people who responded that their overall health was Good, Very Good, or Excellent. Percentage = NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent] / DENOMINATOR [Number of surveys containing responses regarding health reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
NCI Survey	

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

	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = 95% with a margin of error of +/- 9.8*
	☐ *Other Specify:*	*X Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			X Other Specify:
			Sample size deemed appropriate by NCI.

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of participant records reviewed that document training and education were provided to provider staff on how to identify and address health concerns of a participant, including any change in a participant's status that could jeopardize their health and safety in the community. Percentage = NUMERATOR [Number of participant records reviews that document training and education were provided to provider staff on how to identify and address health concerns of a participant, including any change in a participant's status that could jeopardize their health and safety in the community] / DENOMINATOR [Number of participant records reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Participant record reviews, including corresponding provider training records, on-site (Certification)

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

				☐*Other Specify:*
				.

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

Performance Measure:	Number and percent of participants reviewed who had an ambulatory or preventive care visit during the year. Percentage = NUMERATOR [Number of participants who had an ambulatory or preventive care visit during the year] / DENOMINATOR [Number of participants]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
MMIS	

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

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

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

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

Data from the OA will be collected on a monthly basis and reported to AMA. Trends in data

will be addressed as appropriate depending on the results. Remediation by the QE staff in the regional office will identify needs based on trends and act accordingly to minimize variances from the expected goal.

b. Methods for Remediation/Fixing Individual Problems

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

Reports will be sent monthly to the AMA and data will be reviewed. Data reports will be discussed at quarterly meetings to discuss data and trends noticed by AMA. AMA will work with the OA to ensure correction in an efficient manner. Regional nurses are required to monitor 5% the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and reviewed recommendations are made on the Regional Nursing Monitoring on ways to prevent medication errors on the appropriate form. Regional nurses follow-up to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

ii. **Remediation Data Aggregation**

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

		X☐ Other Specify:
		5% of Medication Administration records are reviewed annually.

Quality Improvement:
Financial Accountability

a.i. 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 claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver / 1115 Group 5 document. Percentage = NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver / 1115 Group 5] / DENOMINATOR [Number of claims paid]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Data Aggregation and Analysis

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

Performance Measure:	Number and percent of participant records that show claims were coded correctly, and paid, only for services that were rendered. Percentage = NUMERATOR [Number of participant records reviewed that show claims were coded correctly, and paid, only for services that were rendered] / DENOMINATOR [Number of participant records reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Claims data (ADIDIS) Participant Record Reviews, On-site

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

Data Aggregation and Analysis

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

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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

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

Performance Measure:	Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver / 1115 Group 5 cycle.

	Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology]/DENOMINATOR [Number of rates reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Claims data (ADIDIS)			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
[redacted]	*X Operating Agency*	*☐ Monthly*	*☐Less than 100% Review*
[redacted]	*☐ Sub-State Entity*	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
[redacted]	*☐ Other Specify:*	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

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

☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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

b. Methods for Remediation/Fixing Individual Problems

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

Reports are shared with the Operating Agency and the Performing Provider. Reimbursement made for services not provided in accordance with the PCP, or not sufficiently documented, is recouped. The phrase "not provided in accordance..." is defined as exceeding an average expected rate of utilization by more than 10% and having no documentation for the exception. All waiver services are prior authorized, so that the annual limits on units of service cannot be exceeded, but average utilization, month to month, can vary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X State Medicaid Agency	**☐ Weekly**
	X Operating Agency	**☐ Monthly**
	X Sub-State Entity	**☐ Quarterly**
	☐ Other Specify:	**X Annually**
		☐ Continuously and Ongoing
		☐ Other Specify: