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CHAPTER THIRTY-SIX

HOME- AND COMMUNITY-BASED SERVICES
FOR THE ELDERLY AND DISABLED

Chapter 36. Home-and Community-Based Services for the Elderly and Disabled.

Rule No. 560-X-36-.01 Authority and Purpose

(1) Home and community-based services to the elderly and disabled are provided by the Alabama Medicaid Agency to categorically needy individuals who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of five years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS). Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan.

(2) The purpose of providing home and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Waiver services are not entitlements but are based on individual client needs. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers enrolled for each service included in his or her written plan of care.

(3) Waiver services provided to eligible Medicaid recipients must be identified on the individual's Plan of Care and the Service Authorization Form. Waiver services provided but not listed on the Plan of Care and the Services Authorization Form are not reimbursable. Payments rendered for services not documented on the Plan of Care and the Service Authorization Form will be recovered.

(4) It is not the intent of the E/D Waiver Services program to provide 24-hour in-home care. Should 24-hour in-home care become necessary in order to protect the health and safety of the waiver client, the appropriateness of waiver services should be assessed and other alternatives considered.

(5) Home and Community-Based Waiver Services are provided in compliance with the provisions of the HCBS Settings Final Rule (CMS 2249-F/2296-F). These provisions require the following:

(a) Services may only be provided in settings that:

1. Are integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
2. Are selected by the individual from among setting options;
3. Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
4. Optimize autonomy and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact; and,

5. Facilitate choice regarding services and who provides them.

(b) Services may not be provided in:

1. Excluded settings that include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals; and,

2. Presumed institutional settings that include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 441, Subpart G; and The Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, and May 15, 1990. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Filed April 19, 2023; effective June 12, 2023.

Rule No. 560-X-36-.02 Eligibility

(1) Financial eligibility is limited to those individuals receiving SSI, individuals deemed to be receiving SSI, the optional categorically needy at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services, individuals receiving State Supplementation, and individuals receiving State or Federal Adoption Subsidies.

(2) Medical eligibility is determined based on current admission criteria for nursing facility care as described in Rule No. 560-X-10-.10.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. Discharge planning by a case manager is a reimbursable service.

(4) The Alabama Medicaid Agency or its operating agencies acting on Medicaid's behalf may also deny home- and community-based services if it is determined that an individual's health and safety is at risk in the community; if the cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by CMS.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.
History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed July 20, 2005; effective October 14, 2005. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.03 Operating Agency

The Home- and Community-Based Waiver for the Elderly and Disabled is a cooperative effort among the Alabama Medicaid Agency, and the Alabama Department of Senior Services. The State affirms that it will abide by all terms and conditions set forth in the waiver.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 441, Subpart G; and The Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-36-.04 Covered Services

(1) Case Management Services.

(a) Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services. Case management activities may also be used to assist in the transition of an individual from institutional settings prior to discharge into the community. All E/D waiver recipients will receive case management services.

(b) A person providing Case Management Services must meet the qualifications as specified in the approved waiver document.

(c) Case Management Services must be on the Plan of Care as a waiver service. Waiver services not listed on the Plan of Care and the Service Authorization Form will not be paid. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(d) Case management will be provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

(2) Homemaker Services.

(a) Homemaker Services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. They are provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the recipient.

(b) A person providing Homemaker Services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) Homemaker Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(3) Personal Care Services.

(a) Personal Care Services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, reminding client to take medications, and securing health care from appropriate sources.

(b) A person providing Personal Care Services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and supervised by a licensed nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This person may not be a relative, as defined by CMS, of the recipient.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services furnished by a member of the recipient's family.

(e) Personal Care Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(4) Adult Day Health Services with and without Transportation.

(a) Adult Day Health Service provides social and health care in a community facility approved to provide such care.

(b) Transportation between the individual's place of residence and the Adult Day Health Center can be provided as a component of Adult Day Health Service. Health education, self-care training, therapeutic activities, and health screening shall be included in the program.

(c) Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in Appendix C of the Home and Community-Based Waiver for the Elderly and Disabled. The state agencies contracting

for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

(d) Medicaid will not reimburse for activities performed which are not within the scope of services.

(e) Adult Day Health Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(5) Respite Care Services [Skilled and Unskilled].

(a) Respite Care is given to individuals unable to care for themselves on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite Care is provided in the individual's home and includes supervision, companionship and personal care of the individual. Respite is intended to supplement not replace care provided to waiver clients. Respite is not an entitlement. It is based on the needs of the individual client and the care provided by the primary caregiver.

(b) A person providing Respite Care must meet the qualifications as specified in the approved waiver document.

(c) Respite Care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN, or RN, depending upon the care needs of the individual. All other waiver services except case management will be discontinued during the in-home respite period.

(d) Payment will not be made for Respite Care furnished by a member of the recipient's family; may not exceed 720 hours or 30 days per waiver year (October 1 through September 30); must not be used to provide continuous care while the primary caregiver is employed or attending school.

(e) Medicaid will not reimburse for activities performed which are not within the scope of services.

(f) Respite Care Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(6) Companion Services.

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

(b) A person providing Companion Services must meet the qualifications as specified in the approved waiver document.

(c) Other service definitions include accompanying a client to a medical appointment, grocery shopping or picking up prescription medications. The Companion Service is available to only those clients living alone. Companion Services cannot be provided at the same time as other approved waiver services except for Case Management Services. Companion Services must not exceed four (4) hours daily. Payment will not be made for companion services furnished by a member of the recipient's family.

(d) Medicaid will not reimburse for activities performed which are not within the scope of services.

(e) Companion Service is not an entitlement. It is based on the needs of the individual client.

(f) Companion Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the Plan of Care shall be recovered.

(7) Home Delivered Meals.

(a) Home Delivered Meals are provided to an eligible individual age 21 or older who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of Home Delivered Meals.

(b) This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability/dependency and who require nutritional assistance to remain in the community, and do not have a caregiver available to prepare a meal for them.

(c) This service will be provided as specified in the care plan and may include seven (7) or fourteen (14) frozen meals per week. Clients will be authorized to receive one (1) unit of service per week. One unit of service is a 7-pack of frozen meals. Clients may be authorized to receive two (2) units of service per week. These clients will receive two 7-packs of frozen meals or one 7-pack of frozen meals and one 7-pack of breakfast meals.

(d) In addition to the frozen meals, the service may include the provision of two (2) or more shelf-stable meals (not to exceed six (6) meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

(e) One frozen meal will be provided on days a client attends the Adult Day Health Centers. Meals provided as part of this service shall not constitute a "full nutritional regimen" (three meals per day).

(f) All menus must be reviewed and approved by the Meals Services Coordinator, a Registered Dietitian with licensure to practice in the State of Alabama and employed by the Operating Agency.

(g) The meals must be prepared and/or packaged, handled, transported, served, and delivered according to all applicable health, fire, safety, and sanitation regulations.

(h) Home Delivered Meals must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recouped.

(i) During times of the year when the State is at an increased risk of disaster from hurricanes, tornadoes, or ice/snow conditions, the meals vendor will be required to maintain, at a minimum, a sufficient inventory to operate all frozen meals delivery routes for two days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid approved Disaster Meal Services Plan.

(8) Home Modification Services.

(a) Home Modification Services provide physical adaptations to the home which are necessary to ensure the health, welfare, and safety of individuals, or which enable individuals to function with greater independence in the home, and without this service the individual would require institutionalization.

(b) Providers of Home Modification Services must meet the qualifications as specified in the approved waiver document.

(c) Home Modification Services may include the installation of ramps and grab-bars, widening of doorways to accommodate medical equipment, and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver recipient, adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, and changes to the existing electrical components of the home.

(d) Home Modification Services shall be provided by a licensed contractor and must be in accordance with state and local building codes requirements, and the Americans with Disabilities Act Accessibility Guidelines (ADAAG).

(e) Home Modification Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and Service Authorization Form shall be recovered.

(f) Home Modification Services require prior authorization by the Operating Agency.

(g) Limits on Home Modification Services are $5,000 per waiver participant per lifetime. Any expenditures over the $5,000 lifetime limit must be approved by the Alabama Medicaid Agency.

(9) Personal Emergency Response System (Installation and Monitoring/Monthly).

(a) Personal Emergency Response System (PERS) is an electronic service which enables high-risk recipients to secure help in the event of an emergency. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, without an available caretaker. The recipient may wear a portable "help" button which allows flexibility in mobility. The system is connected to a patient's phone and programmed to signal a response center once a patient's "help" button is activated.

By providing recipients immediate access to assistance, PERS serves to prevent institutionalization.

(b) PERS Monitoring/Monthly covers the monthly fee after the PERS system has been installed.

(c) PERS providers must meet the qualifications as specified in the approved waivers. PERS must be provided by trained professionals. The PERS staff must complete a two-week training period for familiarization with the monitoring system and proper protocol to provide appropriate response action.

(d) Initial setup, installation, and monitoring of PERS must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and Service Authorization Form will be recovered.

(e) Only one installation of PERS per recipient shall be approved. Exception to this limitation shall be considered on an individual basis for circumstances such as relocations.

(10) Medical Supplies.

(a) Medical Supplies are supplies necessary to maintain health and safety in the home environment and to prevent further deterioration of a condition such as decubitus ulcers.

(b) Medical Supplies must be prescribed by a physician and be documented on the Plan of Care and Service Authorization Form.

(c) Providers of Medical Supplies must meet the qualifications as specified in the approved waiver document and shall have signed provider agreements with the Operating Agency.

(d) Medical Supplies shall be billed monthly, quarterly, or annually. The yearly allotment cap shall not exceed $1,200.00. If billed monthly, the monthly cap amount shall not exceed $100.00. If billed quarterly, the quarterly cap amount shall not exceed $300.00. Total cap amounts shall not rollover to another month, quarter, or year.

(e) Medical Supplies must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form will be recovered.

(f) State Plan EPSDT services shall be exhausted prior to any use of waiver services for individuals under the age of 21.

(11) Assistive Technology and Durable Medical Equipment.

(a) Assistive Technology and Durable Medical Equipment includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain, or improve functional capabilities of individuals with disabilities. The service may also be provided to assist an individual to transition from an institutional level of care to the Home and Community-Based Waiver and to maintain a recipient safely in the community.

(b) Assistive Technology and Durable Medical Equipment includes any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application.

(c) Assistive Technology and Durable Medical Equipment can include, but are not limited to wheelchairs, reachers, Hoyer lift, bath benches, etc. Items shall meet applicable standards of manufacture, design, and installation.

(d) Assistive Technology and Durable Medical Equipment must be ordered by the physician. The prescription shall be maintained in the case file.

(e) Assistive Technology and Durable Medical Equipment must be medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records must substantiate the need for the service, and findings and information shall support medical necessity.

(f) Providers of Assistive Technology and Durable Medical Equipment must meet the qualifications as specified in the approved waiver document, be licensed individuals or businesses capable of supplying the needed equipment and/or supplies and have a signed provider agreement with the Operating Agency.

(g) Upon completion of the service, the recipient must sign and date a form acknowledging receipt of the service.

(h) Assistive Technology and Durable Medical Equipment requires prior authorization and approval by the Operating Agency. The maximum allowed for this service is $2,000 per year per waiver recipient up to a total of $10,000 per waiver participant's lifetime.

(i) State Plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.

(j) Assistive Technology and Durable Medical Equipment must be documented on the recipient's Plan of Care and Service Authorization Form. No payments will be made for services not documented on the Plan of Care and Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and Service Authorization Form will be recovered.

(12) Skilled Nursing Services.

(a) Skilled Nursing Services provide skilled medical observation and nursing services by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who will perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing.

(b) Skilled Nursing Services provide skilled medical monitoring, direct care, and interventions for individuals with skilled nursing needs to maintain home support to avoid or delay institutionalization. It is not intended to be provided seven (7) days a week/24 hours a day.

(c) Skilled Nursing Services shall be provided according to guidelines as specified in the approved waiver document.

(d) LPNs may provide skilled care for the recipient if a licensed physician prescribes the service. LPNs work under the supervision of RNs. The RN must make

monthly supervisory visits to evaluate the appropriateness of services rendered by an LPN.

(e) Skilled Nursing Services under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver recipient meets the criteria to receive home health benefits, home health should be utilized first and exhausted before waiver services are utilized.

(f) Skilled Nursing Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for Skilled Nursing Services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care and the Service Authorization Form shall be recovered.

(13) Pest Control Services.

(a) Pest Control Services provide chemical eradication of pests by a State of Alabama Business Licensed and Certified professional in a waiver participant's primary residence, which could be a participant living in his/her own private home or apartment who is responsible for his/her own rent or mortgage or a participant living with a primary caregiver.

(b) Pest Control Services include assessment or inspection, application of chemical-based pesticide and follow up visits.

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

(d) Providers of Pest Control Services must meet the qualifications as specified in the approved waiver document and have a signed provider agreement with the Operating Agency.

(e) A unit is a series. Pest Control Services must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the Plan of Care and Service Authorization Form shall be recovered.

(14) Supervisory Visits.

(a) Supervisory Visits are conducted by Alabama Licensed Registered Nurses or Alabama Licensed Practical Nurses to monitor DSP staff performance to ensure adherence of waiver guidelines, quality of service provision to waiver recipients, and recipient satisfaction with service provision.

(b) Supervisory Visits shall be conducted by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who must meet all federal and state requirements to provide services to eligible Medicaid recipients under this waiver authority.

(c) Supervisory Visits shall be billed in 15 minutes increments not to exceed 60 minutes or 4 increments every 60 days.

(d) No reimbursement will be made for attempted or missed visits.

(e) State Plan EPSDT services will be exhausted prior to any use of waiver services for individuals under the age of 21.

(f) Providers of Supervisory Visits must meet the qualifications as specified in the approved waiver document.

(g) Supervisory Visits must be documented on the recipient's Plan of Care and Service Authorization Form. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the Plan of Care and Service Authorization Form shall be recovered.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 440.180; and The Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Filed April 19, 2023; effective June 12, 2023.

Rule No. 560-X-36-.05 Costs for Services

The costs for services to individuals who qualify for home- and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home- and community-based services were not available.

Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled. Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-36-.06 Application Process

(1) The case manager will receive referrals from hospital, nursing homes, physicians, the community and others for persons who may be eligible for home- and community-based services. For institutional residents residing in a facility for at least 90 days who are interested in transitioning into the community, the case manager should review referrals and intake information. This process will take place during the 180 consecutive day transition period.

(2) An initial assessment will be completed by the case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding

social background, living conditions, and medical problems of the applicant. A redetermination assessment must be completed annually to determine eligibility.

(3) The case manager, in conjunction with the applicant's physician and the client and/or caregiver will develop a plan of care. All services will be furnished pursuant to a written plan of care. Payment will not be made for waiver services furnished prior to the development of the plan of care. The plan of care will include objectives, services, provider of services, and frequency of services. Changes to the original plan of care are to be made as needed to adequately care for an individual. Revisions to the plan of care and the reasons for changes must be documented in the client's case record. Services provided must be documented on the client's care plan which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The Alabama Medicaid Agency has delegated the medical level of care determination to qualified trained individuals at the Operating Agency.

(5) Medicaid requires the providers to submit an application in order to document dates of service provisions to long term care recipients.

(a) The long term care admission notification file maintains these dates of service.

(b) The applications will be automatically approved through systematic programming.

(c) The Alabama Medicaid Agency will perform random audits on a percentage of records to ensure that documentation supports the medical level of care criteria, physician certification, as well as other state and federal requirements.

(6) The Alabama Department of Senior Services (ADSS) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the Elderly and Disabled Waiver.

(7) The Alabama Medicaid Agency will provide to ADSS the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(8) ADSS will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(9) Admissions, readmissions and annual redeterminations must be certified by a physician licensed to practice in Alabama.

(10) ADSS may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(11) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Elderly and Disabled Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

(12) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(13) The Alabama Medicaid Agency may seek recoupment from ADSS for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for Elderly and Disabled Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADSS.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR Section 441, Subpart G; and The Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-36-.07 Financial Accountability of Operating Agency

(1) The financial accountability of providers for funds expended on home- and community-based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a five-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

(2) The state agency, as specified in the approved waiver document as operating agencies of home- and community-based services, will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments that exceed actual allowable cost will be recovered by Medicaid.

(3) The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

(4) The state agency as specified in the approved waiver document will provide documentation of actual costs of services and administration. Such documentation will be

entitled "Quarterly Cost Report for the Elderly and Disabled Waiver." The "Quarterly Cost Report" will include all actual costs incurred by the operating agency for the previous quarter and include costs incurred year to date. This document will be submitted to the Alabama Medicaid Agency before the 1st day of the third month of the next quarter. Quarters are defined as follows:

(a) 1st October - December Due before March 1
(b) 2nd January - March Due before June 1
(c) 3rd April - June Due before September 1
(d) 4th June - September Due before December 1

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed. Quarterly Cost Reports will be reviewed to determine necessity of a field audit.

(5) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments" will apply to governmental agencies participating in this program. For non-governmental agencies, generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(6) Cost, Allowable and Unallowable –

(a) 45 CFR, part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies and will act as a guide for non-governmental agencies. For governmental agencies, all reported cost will be adjusted to actual cost at the end of the waiver year.

(c) Contract payments for the delivery of the specific services are allowable expenses. Thus, contracts for case management, personal care, homemaker, respite care, adult day health, and home delivered meals are recognized expenses. All other contracts will require Medicaid approval to ensure that functions are not being duplicated. For example, outreach is to be performed by the case manager, thus, it would not be appropriate to approve other contracts for outreach, unless it can be clearly shown that the function is required and cannot be provided within the established organization.

(d) Allowable costs are defined in OMB Circular A-87. However, the following restrictions apply:

1. Advertising is recognized only for recruitment of personnel, solicitation of bids for services or goods, and disposal of scrap or surplus. The cost must be reasonable and appropriate.

2. The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding twenty-five thousand dollars will be capitalized in accordance with 45 CFR 95.705 and depreciated through a use allowance of two percent of acquisition cost for building and six and two-thirds percent for equipment. Equipment that has a remaining value at the completion of the project will

be accounted for in accordance with 45 CFR 95.707. For automated data processing equipment, see 45 CFR 95.641. When approval is required, the request will be made to Medicaid agency in writing.

3. The acquisition of transportation equipment will require prior approval from the Alabama Medicaid Agency. When approval is required, the request will be made to Medicaid in writing.

4. Transportation is an allowable expense to be reimbursed as follows:

(i) For nongovernmental agencies, it will be considered as part of the contract rate.

(ii) For government and private automobiles utilized by state employees, reimbursement will be made at no more than the current approved state rate.

(iii) All other types of transportation cost will be supported by documents authorizing the travel and validating the payment.

(e) Unallowable costs are specified in OMB Circular A-87. In addition to these, the following are not covered by this program:

1. Cost covered by other programs, such as:
   (i) Prescription drugs,
   (ii) Dental expense,
   (iii) Physical therapy,
   (iv) Ambulance service,
   (v) Inhalation, group, speech, occupational, and physical therapy.
2. The cost of advisory councils or consultants without Alabama Medicaid Agency's approval.
3. Legal fees as follows:
   (i) Retainers,
   (ii) Relating to fair hearing,
   (iii) In connection with law suits, which result in an adverse decision,
   (iv) Services that duplicate functions performed by Medicaid or the provider, such as eligibility determination for the program,
   (v) Other legal fees not relating to the providing of services to the beneficiaries.
4. Dues and subscriptions not related to the specific services.

(7) Cost Allocation Plans

(a) State agency are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 CFR 95.507, which also calls for written agreements, between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project within a fund, there must be a written plan to distribute fund costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central

office that verifies the quality of service. This cost can be prorated to each service by some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage. The second type of allocated cost falls under the administration definition. For example, a mail distribution clerk that distributes to all programs. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. As a minimum, these contracts should meet requirements of 45 CFR 95.507; these contracts must indicate:

1. "The specific services being purchased."
2. "The basis upon which the billing will be made - - (e.g., time reports, number of homes inspected, etc.)."
3. "A stipulation that the billing will be based on actual costs incurred." This is not a requirement for non-governmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the fiscal year.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR Section 441, Subpart G; and the Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-36-.08 Fair Hearings

(1) An individual whose application to the waiver program is denied or waiver participants whose services are terminated, suspended, or reduced based on Rule No. 560-X-36-.02, may request an appeal in accordance with 42 CFR Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(2) E&D waiver participants will be given at least a ten-day notice before termination, suspension, or reduction of service.

(3) If an individual/guardian chooses to appeal the decision, a written request for an informal conference must be received by the Operating Agency within 30 days from the effective date of the notice. Services may continue for waiver participants until the final outcome of the administrative appeal process, if the written request is received within 10 days after the effective date of the action.

(4) If the individual/guardian is dissatisfied with the Informal Conference decision, a Fair Hearing may be requested. A written request for a Fair Hearing must be received no later than 30 days from the date of the Informal Conference decision notice.

(5) If the individual/guardian is dissatisfied with the Fair Hearing decision, he/she may appeal pursuant to the provisions of the Alabama Administrative Procedure Act.

(6) The Operating Agency will take the lead role for the Informal Conferences, Fair Hearings, and subsequent judicial appeals. Medicaid legal counsel and program staff will function as support staff.

Author: Monica Abron, Associate Director, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR Section 431, Subpart E.
History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987 and May 15, 1990. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-36-.09 Payment Methodology for Covered Services

(1) Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a HCPC code. Respite care will have one code for skilled and another for unskilled. Home delivered meals will also have one code and two modifiers. Frozen meals and shelf stable meals will be billed with a modifier. Breakfast meals will be billed without a modifier.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month, but no single claims can cover services performed in different months. If the submitted claim covers days of service part or all of which were covered in a previously paid claim, it will be rejected. Payment will be based on the number of units of service reported for each HCPC code.

(3) The basis for the cost will usually be based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim cost may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(4) The operating agencies as specified in the approved waiver document are governmental agencies; therefore, within one hundred and twenty days from the end of a waiver year, the interim cost for services must be adjusted to cost and the claims for the services provided during that year reprocessed to adjust payments to the actual cost incurred by each operating agency. Thus the cost for each service for each operating agency may differ. Since the actual cost incurred by each operating agency sets a ceiling on the amount it can receive, no claims with dates of service within that year will be processed after the adjustment is made.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on CMS 372 Report. The following accounting definitions will be

used to capture reporting data, and the audited figures used in establishing new interim cost:

(a) A waiver year consists of the twelve months following the start of any waiver year.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public (governmental) provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by operating agencies are reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

(6) Provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the cost. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and a lump sum settlement will be made to adjust that year's payments to actual cost.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 440.180 and the Home and Community-Based Waiver for the Elderly and Disabled, 45 CFR, Subpart 95, and OMB Circular A-87.
History: Emergency Rule effective December 4, 1987. Rule effective March 12, 1988. Amended May 15, 1990 and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed March 21, 2005; effective June 17, 2005. **Amended:** Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.10 Confidentiality

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his or her attorney, and/or guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program support Unit
Statutory Authority: 42 CFR Section 431.306.
History: New Rule: Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-36-.11 Appeal Procedure for Fiscal Audit

(1) Fiscal audits of the Elderly and Disabled Waiver Services are conducted by the Provider Audit Division of Medicaid. At the completion of the field audit there will be an exit conference with the operating agency to explain the audit findings. The operating agency will have the opportunity to express agreement or disagreement with the findings. The field audit and the comments of the operating agency are reviewed by the Provider Audit Division and a letter is prepared making the appropriate findings official. If the operating agency deems that the findings are not justified, it may request an informal conference with the Director of the Provider Audit Division.

(2) The request for an informal conference must be in writing and received by Medicaid within 30 days from the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to the attention of:

Director
Provider Audit Division

(3) The decisions of the Provider Audit Division made as a result of the informal conference will be forwarded to the operating agency by letter. If the operating agency believes that the results of the informal conference are still adverse, it may request a fair hearing. The request must be in writing and received by Medicaid within 15 days from the date of the informal conference decision letter.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431, Subpart E.
History: New Rule: Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.12 Third Party Liability

The Third Party Division, Alabama Medicaid Agency, is responsible for fulfilling the requirements pertaining to third party liability. The purpose of the Third Party Division is to ensure that Medicaid is the payor of the last resort. Providers shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency within sixty days of receipt of Medicaid payment. For further information concerning Third Party Liability refer to Administrative Code Chapter 20.

Author: Ginger Wettingfield, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 433, Subpart D; Section 1902(a)(25), Social Security Act; Code of Alabama, 1975 Sections 22-6-6.
History: New Rule: Filed July 21, 2008; effective October 16, 2008.