Chapter 58. Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness - REPEALED

Rule No. 560-X-58-.01. Authority and Purpose.

(1) Home- and community-based services for individuals diagnosed with HIV/AIDS or related illness are provided by the Alabama Medicaid Agency to persons who are Medicaid-eligible under the waiver and who would, but for the provision of such services, require the level of care available in a nursing facility. These services are provided through a Medicaid waiver under provisions of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act, for an initial period of three (3) years and renewal periods of five (5) years thereafter upon waiver approval by the Centers for Medicare and Medicaid Services (CMS).

(2) The Operating Agency for the HIV/AIDS Waiver is the Alabama Department of Senior Services. The Operating Agency is responsible for the day-to-day operations of the waiver program. This includes managing the program by focusing on improving care for the client, protecting the health and welfare of the client, giving the client free choice of providers and waiver service workers, and making sure all direct service providers meet the qualifications as outlined in the waiver document.

(3) Home and community-based services covered in this waiver are Case Management, Homemaker Services, Personal Care, Respite Care, Skilled Nursing and Companion services. These services provide assistance necessary to ensure optimal functioning of individuals diagnosed with HIV/AIDS and related illness.

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements; and the Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness.
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Rule No. 560-X-58-.02. Description of Services.

Home and Community-Based Services are defined as Title XIX Medicaid-funded services provided to individuals diagnosed with HIV/AIDS or persons with related conditions who, without these services, would require services in a nursing facility. These services will provide health, social, and related support needed to ensure optimal functioning of the individual within a community setting. The operating agency may provide or subcontract for any services provided in this waiver. To qualify for Medicaid reimbursement each individual service must be necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. The specific services available as part of the HIV/AIDS Waiver are:

(1) Case Management Services.

(a) Case management is a system of providing services which will assist waiver recipients in gaining access to needed, and desired waiver and other state plan services, as well as needed medical, social, educational and other services, regardless of the funding sources for the services to which access is gained. 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 for up to 180 days prior to discharge into the community.

(b) Case managers are responsible for care plan development and ongoing monitoring of the provision of services included in the recipient's care plan.

(c) Case management will be provided by a case manager employed by or under contract with the state agency 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. The service is provided by a trained homemaker when the individual responsible for these activities is temporarily absent or unable to manage the home and care for himself.

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

(3) Personal Care

(a) The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

(b) PC Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs).

(c) PC may include assistance with independent activities of daily living (IADLs) such as meal preparation, but does not include the cost of the meals themselves, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

(4) Respite Care—Skilled and Unskilled

(a) The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems.

(b) This service will provide temporary, short-term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

(c) Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence of the primary caregiver.

(d) The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager if case management is elected by the client. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination. Medicaid will not reimburse for activities performed which are not within the scope of services defined.

(5) Skilled Nursing

(a) The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing.

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

(6) Companion Services

(a) Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult.

(b) 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.

(c) The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual.

(d) Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely recreational in nature.

(e) 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.

(f) Companion Services are only available to recipients who live alone and may not exceed four hours daily.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
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Rule No. 560-X-58-.03. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, deemed to be receiving SSI and optional categorically needy at a special income level of 300 percent of FBR,

State Supplementation, individuals eligible for the Pickle program (continued Medicaid); deemed disabled widow and widowers from age 50 but not yet age 60; early widow and widowers age 60-64; disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability; those individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse; and Medicaid for Low Income Families (MLIF).

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10. In addition, waiver services are limited to individuals age 21 and over, who have been diagnosed with HIV/AIDS or related illness.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition are limited to a maximum of 180 days.

(4) The Alabama Medicaid Agency may 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 individual does not cooperate with a provider in the provision of services; or if an individual fails to meet the goals and objectives of being on the waiver program.

(5) Financial determinations and redeterminations shall be made by the Alabama Medicaid Agency, the Alabama Department of Human Resources or the Social Security Administration, as appropriate. In addition to the financial and medical eligibility criteria, the Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by CMS.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
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Rule No. 560-X-58-.04 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.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.

History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-58-.05. Application Process.

(1) Case managers will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community-based services.

(2) The case manager will complete a needs assessment to assist with the development of the Plan of Care. The medical information obtained from the client's primary physician is considered in development of the plan. This document will reflect detailed information regarding social background, living conditions and medical problems of the applicant. A copy of this document will be submitted to the Operating Agency for review and approval.

(3) The case manager, in conjunction with the client, family or legal representative, if applicable, and other person designated by the client will develop a participant-centered Plan of Care. The Plan of Care will include objectives, services, providers of services and frequency of service. The Plan of Care must be submitted to the Operating Agency for approval. Changes to the original Plan of Care should be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's Plan of Care, which is subject to the review of the Operating 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.

(a) If the Alabama Department of Senior Services RN determines that the documentation does not support the individual's need for the level of care as determined by the case manager and the attending physician, the documentation will then be forwarded to the Alabama Medicaid Agency's Long Term Care Quality Improvement Coordination Unit for nurse review. If a denial is issued, the applicant/recipient will receive a notice informing them of his/her right to an informal conference and/or a fair hearing.

(4) The Medicaid Nurse Review Coordinator will perform a retrospective review of a random sample of approved applications on a monthly basis. The purpose of this review is to ensure compliance with both state and federal guidelines. If problems are identified the operating agency will be notified in writing within 30 days of receipt of the documentation by the Alabama Medicaid Agency. A corrective action plan will be requested. Results of the audit may lead to recoupment of funds.

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements; and the Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness.
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Rule No. 560-X-58-.06. Informing Beneficiaries of Choice.

(1) The case manager will be responsible for ensuring that applicants of the waiver service program are advised of the feasible service alternatives and be given a choice of which type of service—institutional or home and community-based services—they wish to receive.

(2) Residents of long-term care facilities, and/or a designated responsible party with authority to act on the applicant's behalf, for whom home and community-based services become a feasible alternative under this waiver will be advised of the alternative at the time of review.

(3) All applicants determined to be eligible for home and community-based services will be offered the alternative. Provisions for fair hearings for all persons ineligible for services under this waiver will be made known to potential eligibles in accordance with Fair Hearings Procedures in the Alabama Medicaid Program.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-58-.07. 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-58-.03, may request an appeal in accordance with 42 CFR Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code, as modified by the below provisions.

(2) HIV/AIDS waiver participants will be given at least a ten-day notice before termination, suspension or reduction of services.

(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: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431, Subpart F. **History:** New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-58-.08. Payment Methodology for Covered Services.

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(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; however no single claim can cover services performed in different months. For example, a claim with dates of service of 5/15/03 to 6/15/03 is not allowed. If the submitted claim covers any dates of service which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(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 a direct service provider agency is reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
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Rule No. 560-X-58-.09. 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/her attorney or legal representative, or upon subpoena from a court of appropriate jurisdiction.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431.306, Subpart F—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-58-.10. Records.

(1) The Alabama Department of Senior Services shall make available to the Alabama Medicaid Agency (AMA) at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature or designated signature authority.

(3) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five-year period. These records must be accessible to the AMA and appropriate state and federal officials.

(4) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The AMA and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements; and the Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-58-.11. Service Providers.

The Home and Community-Based HIV/AIDS Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Senior Services.

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements; and the Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness.
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Rule No. 560-X-58-.12. Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations and the *Alabama Medicaid Provider Manual*.

(2) General enrollment instructions and information can be found in Chapter 2, "Becoming a Medicaid Provider", of the *Alabama Medicaid Provider Manual*. Failure to provide accurate and truthful information or intentional misrepresentation may result in action ranging from denial of application to permanent exclusion and criminal prosecution.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Repealed:** Filed May 22, 2018.