

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

### 1. Major Changes

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

The most significant changes to this waiver are updates to service definitions to align with CMS core definitions, updates to performance measures based on new CMS requirements, additional services that can be self-directed with budget authority, additional services that encourage community integration (i.e. housing stabilization), and shifting from a per diem model to 15 minute unit for day services.

Due to the State's fiscal situation, no expansion in capacity is being projected. With the level funding, the State will be able to replace all the individuals who are expected to leave the waiver each year, but not to expand capacity. Still, it is the desire of the Division to grow the supports waiver that focuses more on independent living. If any new money should be appropriated to the Division or dollars are saved through systems transformation the supports waiver will be expanded.

An additional change will be made to standardize the nomenclature to be consistent with CMS. Updates will be made to the diagnosis codes, qualified profession staff title, and any inconsistency with the Operating Agency's name. The Operating Agency for this waiver is the Division of Developmental Disabilities within the Alabama Department of Mental Health. In a previous legislative session a bill was passed that changed the Department's name to simply the Alabama Department of Mental Health. This has allowed the Division to change its name to the Division of Developmental Disabilities. There is no intent to change eligibility or expand coverage at this time: the purpose of the name change is to remove reference to the term "retardation."

References to the Operating Agency in this Renewal Application will consist of the following terms, all of which are intended to mean the same thing: Department of Mental Health, DMH, Division of Developmental Disabilities, and DDD. Note that considerable effort has been put into editing the text in this waiver renewal application. References to the previous names for the Operating Agency may still appear. Such appearance is unintentional, and if found they will be corrected. Nonetheless, in the present document, all these terms refer to the Operating Agency.

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

### 1. Request Information (1 of 3)

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

- B. Program Title** *(optional - this title will be used to locate this waiver in the finder):*  
**Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH Waiver)**
- C. Type of Request:** renewal
- Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*
- 3 years  5 years
- Original Base Waiver Number:** AL.0391  
**Draft ID:** AL.008.03.00
- D. Type of Waiver** *(select only one):*  
 Regular Waiver ▼
- E. Proposed Effective Date:** *(mm/dd/yy)*  
 10/01/15

### 1. Request Information (2 of 3)

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- F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies):*
- Hospital**  
 Select applicable level of care
- Hospital as defined in 42 CFR §440.10**  
 If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**
- Nursing Facility**  
 Select applicable level of care
- Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**  
 If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**  
 If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

### 1. Request Information (3 of 3)

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- G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities  
 Select one:
- Not applicable**
- Applicable**  
 Check the applicable authority or authorities:
- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

**A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

**A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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

This waiver supports Alabama citizens who have a diagnosis of Intellectual Disabilities and who would otherwise require the level of care offered in an ICF/IID to remain in their communities. The waiver is operated by the Alabama Department of Mental Health (DMH) under an agreement with, and supervision by, the Alabama Medicaid Agency. The waiver is administered by the DMH through its Division of Developmental Disabilities, which operates five regional offices and contracts with 28 local public agencies known as 310 Boards from their enabling legislation. The 310 Boards provide case management. Eligibility is determined and due process notification administered by the regional DMH/DDD offices, which also approve plans of care, prior authorize funding, and monitor both case management and waiver services.

This waiver is a support waiver, with a cost cap, for individuals who do not need a formal, paid residential setting, and who can achieve an adequate and appropriate level of support with funding that does not exceed the cost cap.

## 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes
- If yes, specify the waiver of statewideness that is requested (*check each that applies*):
- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
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- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver*

by geographic area:

## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would

receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to

individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver: The Department of Mental Health hosts a formal advisory body known as the Management Steering Committee, which includes representatives of provider agencies, representatives of advocacy agencies, and direct consumers or their families, from the three service areas operated by the Divisions of the Department. These are the Divisions of Substance Abuse, Mental Illness, and Developmental Disabilities. The Management Steering Committee meets monthly to review reports and recommendations from Divisional sub committees and from the Divisions themselves, and to make recommendations to the Commissioner of the Department of Mental Health, which is a Cabinet Level Appointment by the Governor.

Each of the three Divisions hosts a Divisional Subcommittee of the Management Steering Committee. The Subcommittee structure allows a broader range of input. The Divisional Subcommittee for Developmental Disabilities includes an individual who receives services and a family member from each region. There are also four representatives from 310 agencies (which provide case management, among other functions), three representatives from the ARC of Alabama (advocacy), one of whom is a consumer, four providers at large, two representatives of People First, one representative of the Developmental Disabilities Council and one representative of the Protection and Advocacy Agency for Alabama. The Division provides three members, including the Associate Commissioner, and the Department provides a member of the Advocacy Office staff and a person from the Policy and Planning Office. The Divisional Subcommittee takes part in planning and recommending approval of, actions of the Division, including development of waiver services.

In addition to this formal operational structure, the planning effort described in Appendix H, which was started in fiscal 2007 and expanded statewide in fiscal 2008, provides an opportunity for literally hundreds of stakeholders to learn how the system operates and provide input into what they would like added, deleted, or otherwise changed. While this planning is not specific only to the waiver programs, the waiver programs are a major operational structure, and as such are discussed extensively.

Finally, the Division of Developmental Disabilities will post the draft LAH Waiver Renewal on the Department's web page in order to obtain Public Comment. Public Comment period will be 30 calendar days. The AL Medicaid Agency will also post the draft on their website and collect public comment. Comments will be reviewed for recommendations. If there are significant changes made to the draft waiver based on the public comment then a second draft will be posted on both the DMH and AMA websites and again public comment will be requested.

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

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

## 7. Contact Person(s)

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

**Last Name:**   
**First Name:**   
**Title:**   
**Agency:**   
**Address:**   
**Address 2:**   
**City:**   
**State:** **Alabama**  
**Zip:**   
**Phone:**  **Ext:**   **TTY**  
**Fax:**   
**E-mail:**

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

**Last Name:**   
**First Name:**   
**Title:**   
**Agency:**   
**Address:**   
**Address 2:**   
**City:**   
**State:** **Alabama**  
**Zip:**   
**Phone:**  **Ext:**   **TTY**  
**Fax:**   
**E-mail:**

## 8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

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Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alabama**

Zip:

Phone:  Ext:   TTY

Fax:

E-mail:

## Attachments

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### Attachment #1: Transition Plan

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).

- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

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

Alabama has reviewed the new HCB setting requirements for the Living At Home Waiver and has confirmed that this waiver is in compliance with the new regulations. The Living At Home Waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions.

The Alabama Medicaid Agency requested public comments on August 28, 2015 for its Living At Home Waiver Transition Plan. The public was invited to submit comments and questions on the plan from August 28, 2015 through September 26, 2015. Individuals were directed to submit their comments to Samantha McLeod, Associate Director by email at [Samantha.mcleod@medicaid.alabama.gov](mailto:Samantha.mcleod@medicaid.alabama.gov) or by postal mail to: Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624.

#### Public Notice Announcement

A public notice was posted to the Alabama Medicaid Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and broadcast via email to over 2,000 state-wide contacts. This notice included Alabama's compliance justification for the Living At Home Waiver Transition Plan requirement.

A second public notice with the same language was posted to the Department of Mental Health's website. Additionally, the public comment period was announced with a notice in the Birmingham News newspaper (the largest circulated newspaper in Alabama) and its affiliate, Al.com that includes other newspaper sponsors such as the Huntsville Times, Mobile Press-Register, and Montgomery Independent. The comments were reviewed for recommendations. No revisions are needed for the submission of the Living At Home Waiver Transition Plan.

#### Public Notice for the State of Alabama Living At Home Waiver Transition Plan Requirement

e Alabama Medicaid Agency is seeking public comment on its compliance response for State of Alabama Living At Home Waiver transition plan. The Living At Home Waiver provides home and community-based (HCB) services to individuals with a diagnosis of Intellectual Disabilities; individuals meeting the Intermediate Care Facility for Individuals with Intellectual Disabilities Level of Care; persons not residing in a group home setting or environment; and persons currently on

the waiting list for ID services.

## Background

The Centers of Medicare and Medicaid (CMS) published a new rule that requires 1915c Home and Community-Based Service Waivers to submit a transition plan according the requirements recorded in 42 CFR 441.301(c)(4).

These new regulations will ensure that Medicaid participants receive HCB services that are appropriate based on the needs of the individual as indicated in their person-centered service plan and in settings that meet the requirements specified below. HCBS Waiver Settings Must:

Be integrated in and supports access to the greater community

Provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid Home and Community-Based Services.

Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources)

Ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint

Optimize individual's initiative, autonomy, and independence in making life choices

Facilitate individual's choice regarding services and supports, and who provides them

Provide for, at minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city, or other designated entity.

The Alabama Department of Mental Health and its Contracted Providers completed site assessments for Residential and Day Habilitation sites from September 2014 through November 2014 for purposes of renewing Alabama's ID Waiver. Sites deemed not to be in compliance had to submit plans of correction and/or compliance to remediate identified practices. Compliance with plans of correction will be reviewed by state certification staff beginning January 2016. All day service providers must be in compliance with their approved plan of correction by January 2018 or be decertified. Services provided under the LAH Waiver are generally provided in the person's or family's home and meet the settings requirement as defined in the HCBS rule. The one exception under the LAH is Day Services. However, persons participating in the LAH waiver and receiving day services were included in the sample for the site assessment conducted as part of the ID Waiver renewal. Therefore, any issues related to noncompliance with settings rule for persons receiving services through the LAH, have already been addressed.

Therefore, based upon Alabama's assessment and review of the new HCB setting requirements, the State has confirmed that persons participating in Day Services through the LAH waiver are in compliance with 42 CFR 441.301(c)(4) or are participating in the remediation process for services at those sites deemed not to be in compliance. Therefore, no further transition plan is required for this waiver.

Written comments of this notice will be received from August 28, 2015 through September 26, 2015. Individuals must send their comments to Samantha McLeod, Associate Director via mail to: Alabama Medicaid Agency, Long Term Care Division, P.O. Box 5624, Montgomery, Alabama 36103-5624 or by submission via e-mail to [Samantha.mcleod@medicaid.alabama.gov](mailto:Samantha.mcleod@medicaid.alabama.gov). Comments will be available for public review at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) in the Program Section under Long Term Care Services.

## **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

**The Alabama Department of Mental Health, Division of Developmental Disabilities**

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

## Appendix A: Waiver Administration and Operation

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2. **Oversight of Performance.**

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

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

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the

Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As the administering agency the Alabama Medicaid Agency ensures that the:

- Operating agency adheres to all federal guidelines described in the approved waiver document
- Health and safety of the client is protected
- Client has been given freedom of choice between institutional care and community care
- Direct service providers meet the qualifications as outlined in the approved waiver document; and signs all subcontracts of qualified direct service providers enrolled with the operating agency.
- Client is aware of their rights to express concerns regarding service provision and/or direct service providers.

The Medicaid Agency provides ongoing oversight of this waiver program by assuring level of care determinations, plans of care, and other necessary documentation is correctly submitted and reviewed. This is accomplished by a direct review of at least 5% random sample of application and renewal documents per month.

In addition, the Medicaid Agency maintains ongoing oversight and authority over the program by:

- Conducting joint training with direct service providers enrolled to provide services through the Living at Home waiver program.
- Participating in training provided periodically by the operating agency to discuss policies and procedures in an effort to consistently interpret and apply policies related to the LAH waiver program.
- Conducting annual training for all operating agency staff to disseminate policies, rules and regulations regarding the home and community based services waiver programs.
- Performing annual reviews conducted by LTC Waiver Quality Assurance Unit to assure the provisions of the interagency agreements are executed and all the assurances in the waiver are being met. The reviews include, but are not limited to provider's records, plans of care, staff qualifications and training, and case management services and monitoring.
- Annual reviews of Quality Enhancement Plan and Activities, quarterly review of complaints made to the Office of Advocacy, including the resolution of same, and participation in stakeholder task forces to assure that proposed improvements meet Medicaid requirements.
- Establishing policies and procedures for operating agency, direct service providers and targeted case managers to ensure services are provided as specified in the approved waiver document.
- Conducting quarterly surveys of satisfaction for a sample of Waiver participants.
- Conducting desk reviews of all provider agencies serving sampled Living at Home Waiver participants.

## Appendix A: Waiver Administration and Operation

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

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

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

In order to implement self directed services, two types of contracted entities will be utilized. The first is a Financial Management Services Agency (FMSA) which will provide fiscal intermediary and other services to participants who choose to self-direct their services. The FMSA was selected by a competitive RFP process, and this FMSA is being utilized by the Alabama Medicaid Agency and at least two other state agencies currently. The services of the FMSA are described in detail in Appendix E, which will include assuring "Qualified Provider Enrollment" and "Execution of Medicaid Provider Agreements."

The second type of contracted entity will consist of no more than five Self-directed Liaisons who will be trained by the Operating Agency and the FMSA to provide detailed information about self-direction, its set-up, implementation, benefits and responsibilities. This function may take place before the person is actually enrolled in the waiver, therefore making it impossible for the self-directed consultant to be reimbursed under the waiver.

The Self-directed Liaisons, as described in Appendix E-1, are considered temporary and will conduct the initial

train-the-trainer trainings once the program has been established and stabilized. The Self-directed Liaisons will have knowledge and experience in the field of Intellectual Disabilities, who have no conflict of interest, and who are willing to be trained and provide detailed information and material to families and participants who indicate an interest in possibly using this service option. Due to the temporary nature of this position, the Operating Agency will not be acting in this capacity, but instead the liaison will work with the FMSA to develop the training and program implementation.

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

## Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

The waiver is administered by the DMH through its Division of Developmental Disabilities Services, which operates five regional offices and contracts with 28 local public agencies as 310 Boards. These Public Corporations were established under Act 310 of the Alabama Code to provide case management to persons enrolled in the Living at Home Waiver and assist persons wishing to apply for the LAH Waiver, by helping the person/family gather and prepare the necessary documentation to submit to the Division of Developmental Disabilities Regional Offices.

## Appendix A: Waiver Administration and Operation

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5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions: Case management activities are subject to annual certification survey and quarterly regional office monitoring by the Division of Developmental Disabilities, on site. Also, the Alabama Medicaid Agency LTC Waiver Quality Assurance Staff monitor all case management (and waiver) agencies annually.

The contracted entities which will be used to implement self-directed services are discussed at length in Appendix E.

## Appendix A: Waiver Administration and Operation

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

The Division of DD uses the Assessment Tool for Basic Assurances®, a tool developed with CQL that has established 13 Basic Assurances® that must be met in order for the program to be certified as a waiver provider.

Assessment Tool for Basic Assurances®

This section is divided into thirteen Basic Assurances® factors:

Factor One: Rights Protection and Promotion

Factor Two: Dignity and Respect

Factor Three: Natural Support Networks

Factor Four: Protection from Abuse, Neglect, Mistreatment and Exploitation

Factor Five: Best Possible Health

Factor Six: Safe Environments

Factor Seven: Staff Resources and Supports

Factor Eight: Positive Services and Supports

Factor Nine: Continuity and Personal Security

Factor Ten: Basic Assurances® System

Factor Eleven: Other Requirements Supporting Protection, Health and Safety

Factor Twelve: Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment Services at an Integrated Worksite (non-congregate services)

Factor Thirteen: Case Management Standards

There are two methods involved in assessing whether an organization meets the Basic Assurance® standards:

Factors Four, Five and Six

The expectation is that the organization has strong systems and practices in place to promote protection, health and safety. Therefore, the criteria for Factors Four, Five and Six-- Protection from Abuse, Neglect, Mistreatment and Exploitation, Best Possible Health, and Safe Environments-- is set at 100%. The system and the practice for all Indicators in each Factor must be present to meet the 100% mark. Additional requirements in these areas (Protection, Best Possible Health, and Safe Environments) are captured in Factor Eleven, which is scored differently, as described below.

Factors One, Two, Three, Seven, Eight, Nine, Ten, Eleven, Twelve and Thirteen

Each Factor is composed of several indicators. Each of the Indicators in Factors One through Three and Seven through Thirteen are assessed and a rating made on one of the following criteria:

Action Required (AR)--Incomplete planning and action.

Progress Noted (PN)--Planning and action has occurred with evidence of partial results.

Effective Results (ER) --Actions are demonstrating the desired results.

When available, the reviewer will identify the evidence source that resulted in a requirement not met/not in compliance finding. This reference may identify a location, a record, specific observation or information disclosed during an interview. The evidence identified in this report is not intended to be inclusive of all instances where standards are not met; but rather a reflection of findings during the site visit. It is the obligation of the organization to ensure that all sites, services and documentation are in compliance with the certification standards.

Information Gathering

Probes, correlating with the requirements in Chapter 580-5-33, Administrative and Support Requirements for Community Providers of Developmental Disability Services, are included in this Assessment Tool as a means of discovering information about the Indicators and making rating decisions. They are not scored separately but are used to gather information to support the decision about whether the Indicator is being met satisfactorily.

The reviewer will make a decision about each Indicator based on the information gathered through conversation, spending time with people and review of documents. The reviewer will evaluate compliance with requirements within the Indicator and then make a final determination about the Indicator based on a preponderance of the information gathered. The reviewer will note Supporting Information for all Indicators rated "Action Required" (AR) and for those individual standards within Indicators rated "Progress Noted" (PN).

### Scoring and Certification

Each organization will be subject to the requirements in Factors and Indicators based on the types of services provided (see chart following this discussion). The total number of the Indicators applicable for that organization is multiplied by 80% to determine the required number of met Indicators for a One Year Certification and 90% for a Two Year Certification. Rounding is applied to the nearest whole number, with .5 being rounded up. Individual Indicators determined by the reviewer to be not applicable for a particular situation will be deleted from the total Indicators required for that organization and this will be factored into the scoring.

The organization's Indicator rankings are added together to obtain the total number of Indicators meeting the "Progress Noted" (PN) and/or "Effective Results" (ER) status.

- If the organization does not meet the 100% criteria for Factors Four, Five and Six, AND/OR does not meet the minimum of 80% on other applicable Indicators, the organization will be determined not in substantial compliance with standards and will not be certified. The organization may be placed on Provisional Certification Status for up to sixty (60) days, and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office. Timeframes to come into full compliance with the indicators must be included in the Plan of Action. Failure to submit the Plan of Action within the time period specified may result in the immediate decertification of the organization's programs. Prior to the expiration of Provisional Certification status, the programs will undergo a follow-up site certification review to determine future certification status.
- If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 80% of the other applicable Indicators, the organization is certified for one year and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office.
- If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 90% of the other applicable Indicators, the organization is certified for two years.

The following chart indicates how the Factors and Indicators are applied per organization based on the services provided:

Total Indicators Applied to the Organization Minimum Number of PN+ER Required for 80% Criteria Minimum Number of PN+ER Required for 90% Criteria

30 24 27  
 31 25 28  
 32 26 29  
 33 26 30  
 34 27 31  
 35 28 32  
 36 29 32  
 37 30 33  
 38 30 34  
 39 31 35  
 40 32 36  
 41 33 37  
 42 34 38  
 43 34 39  
 44 35 40  
 45 36 41  
 46 37 41  
 47 38 42  
 48 38 43

### Examples:

- An organization providing Case Management only is subject to meeting the requirements in 33 Indicators. The organization will need to rate PN or ER on 26 Indicators for a One Year Certification (80% of 33 Indicators = 26.4, rounded to 26). The organization will need to rate PN or ER on 30 Indicators for a Two Year Certification (90% of 33 Indicators = 29.7, rounded to 30).

- An organization providing Case Management services as well as one or more of the Non-Congregate services is subject to meeting the requirements in 36 Indicators (33 for Case Management, and an additional 3 Indicators in Factor Thirteen). A One Year Certification will require a rating of PN or ER on 29 (28.8) Indicators, and a Two Year Certification will require a rating of PN or ER on 32 (32.4) Indicators.

Contracted entities which will be used to implement self-directed services:

Division of Developmental Disabilities staff pulls a scientifically calculated random sample of recipients and reviews the pertinent records for these individuals. Alabama Medicaid Agency Waiver Quality Assurance staff also pulls a random sample in order to review the required records.

The contracted entities which will be used to implement self directed services, and the methods, personnel and frequency of assessing their performance are discussed at length in Appendix E.

The Self-directed Liaisons will be trained by state staff and by the FMSA, in order to have the detailed knowledge with which to assist participants and their families. All training material, employment forms, information packets, brochures and manuals will have the approval of the Alabama Medicaid Agency prior to implementation. The Self-directed Liaisons will be reporting to the regional offices of the Operating Agency, and the regional offices will approved their work or not, based on a variety of feedback. Feedback from the FMSA, case managers, and families will inform the Operating Agency of the effectiveness or lack of effectiveness of any individual consultant. If necessary, retraining will be implemented for ineffective consultants, replacement of a consultant could be required if families are not receiving the necessary support. Communication between the regional offices and the consultants will be frequent, weekly or even daily, as the process for training and implementation of self-directed services will be detailed therefore evaluation frequency is ongoing.

The Operating Agency, contracted self-directed liaison (SDL) and the contracted financial management agency (FMA) work together to ensure the administration of self-directed services are in accordance with waiver requirements. The self-directed liaison and the regional fiscal manager (CPA) both ensure that time cards are accurate and claims are submitted based on the accuracy of the time cards processed by the financial management agency. The contracted self-directed liaison has constant and direct contact with the FMA due to the pre-employment work that is necessary for the employment process to begin its process. Any issues or concerns that the SDL has is directly brought to the attention of the Operating Agency and addressed in a timely manner. The SDL works directly with each regional office and with the case management agency responsible for the waiver participant's planning. It is the responsibility of the regional offices of the Operating Agency to report any instances in which the SDL is not functioning in accordance with waiver requirements.

The oversight methods that encompass each function that is performed by contracted entities or local/regional non-state entities as specified in item A-7 include the FMA is required to submit time cards that have been processed, training documentation, license documentation, and a complete employee packet to the Operating Agency for review. The frequency for this review is quarterly. The SDL submits documentation of activities completed as part of the contract process on a monthly basis. Additionally, there is a RFP process every two years for the FMA to ensure all required tasks set forth by the Operating Agency can be fully implemented. The SDL's contract is also reviewed every two years and the job scope is listed as requirements for extending the contract.

## Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity

Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

##### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**1. Number and percent of self-directed employees/staff that have a Provider Enrollment Agreement with the FMSA, thus complying with state regulations and agreeing to AL Medicaid oversight. Percent equals the number existing SD employees/staff that are**

enrolled with FMSA divided by the number of existing self-directed employees/staff.

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: The Fiscal Management Agency enrolls all SD employees, as well as collects and reviews all training verification records.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**2. Number and percent of case management provider reviews conducted in accordance with waiver policies and procedures. Percent equals number of case management provider reviews conducted in accordance with waiver policies and procedures divided by number of service provider reviews completed during the period.**

**Data Source (Select one):**

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**3. Number and percent of sampled, responding participants who express satisfaction with their services. Percent equals number of responding participants who express satisfaction divided by the total number of responding participants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Information is gathered and grouped from satisfaction surveys, on-and-off site record reviews, and on-site inspection.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: In the aggregate, at least 10% random sample of participants per year.
<input type="checkbox"/> Other Specify: <input type="text"/>		

**Data Aggregation and Analysis:**

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

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

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 by the University of Alabama at Birmingham, from that institution's analysis of the original CMS protocol specifications, and the methodology is used for quality assurance reviews of all the Alabama Medicaid Home and Community-Based Waivers. Measure number three is an example of this methodology.

**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.

The first measure, should non-enrolled/non-trained self-directed providers be found, the money paid will be recouped. The Operating Agency will ensure that all non-certified self-directed employees have been verified and approved through the FMSA employment process via the FMSA packet reviews and time-card submission process, as well as case manager quarterly follow-up and self-directed liaison review. If this is not the case then the immediate response by the Operating Agency will be to ensure the health and safety of the person being served while a more thorough investigation is conducted. If it is determined that the safety of the person is at risk then the Operating Agency will look for alternative means of service provision. This could mean placing the person into the traditional personal care service, where the Operating Agency certifies the personal care provider, until the self-directed employee is either established through the FMSA employment process or replaced.

The second measure is based on the AL Medicaid Agency's Annual Quality Assurance review. It is during this review, which spans two fiscal years, AMA pulls the case management provider's site visit review to ensure full remediation. DMH/DDD will gather pertinent information that supports certification findings and AMA will review all the documentation to the point of resolution. If there is an issue with documentation or a failure to remediate the AMA will include details in their findings report. DDD will correct any area of non-compliance and AMA will review the following year.

The third measure is 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)

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

c. Timelines

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

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

<input type="checkbox"/>	Medically Fragile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both				
<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Intellectual Disability	3	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness				
<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

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

Specify:

## Appendix B: Participant Access and Eligibility

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

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
  - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

Specify:

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

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

The Living at Home Waiver (0391.90) has been approved with a cost limit (other than for crisis intervention) of \$25,000. The limit is based on claim analysis and rates for services in a comprehensive waiver servicing the same population (0001.90), exclusive of group home costs because 0391.90 does not reimburse residential settings. The \$25,000 limit allows for the synchronization of services and rates between the two waivers, which allows some individuals with higher level of needs to use the Living at Home Waiver to remain at home.

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

1. The prioritization list indicates the services which the person needs and gives an initial indication of who might not need to exceed the cost limit.
2. The planning team understands the limitation and will not proceed if the planned services need to exceed the limit. There is also flexibility in the services selected, and the scope of the coverage most often lets the team develop a plan within the financial limit.
3. The plan of care is assessed for cost and will not be approved if it exceeds the limit.

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

An exceed the capped amount can be requested by the case management provider when a participant's circumstances change, either temporarily or permanently, or in an event of a rate increase that affects the overall capped amount. The request for action (RAF) must provide written documentation thoroughly justifying the request to the Regional Director. The Regional Director must approve each request individually. No RAF in excess of \$5,000.00 will be approved for any waiver participant. Any individual requiring more than an additional \$5,000.00 of waiver services may be transitioned into the Intellectual Disabilities Waiver.

Crisis intervention is not included in the costs cap. This allows an individual to be served during a period of higher than expected need and either stabilized and returned to the previous scheduled or transitioned to the Waiver for persons with Intellectual Disabilities.

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	569
Year 2	569
Year 3	569
Year 4	569
Year 5	569

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

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

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

**Table: B-3-b**

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

## Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes
Participants transitioning from school or a facility based setting

## Appendix B: Participant Access and Eligibility

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

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

Participants transitioning from school or a facility based setting

**Purpose** *(describe):*

New admissions to the waiver who are transitioning from school or from a facility based setting and in need of support services to live fully integrated within the community which allows them to have meaningful lives.

**Describe how the amount of reserved capacity was determined:**

The Department of Mental Health, Division of Developmental Disabilities has been focused on supported employment as it relates to children transitioning out of the education system. This year, the Division implemented two Project Search sites within the state. This project is about employment

emersion with a focus on training and transitioning senior year students into competitive and integrated employment upon completion of the program. The project involves various state agencies. For its part, the division would like to assist with long term services to the extent a student is eligible for the supports waiver.

In addition, the Department of Mental Health is working with the Alabama Medicaid Agency with the Money Follows the Person Rebalancing Demonstration Program. A key component is the availability of services through various waivers if a person is eligible.

The two target groups historically have not transitioned or outplaced a large number of people eligible for services through this waiver. The reserved slot number therefore has been set low.

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

Waiver Year	Capacity Reserved
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	35
Year 4	35
Year 5	35

## Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

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

Individuals on the prioritization list who are not waiting for Residential (Group Home) Services are first offered services, in rank order, under this waiver.

## Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No  
 Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

- Low income families with children as provided in §1931 of the Act  
 SSI recipients  
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
 Optional State supplement recipients  
 Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)  
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
 Medically needy in 209(b) States (42 CFR §435.330)  
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)  
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134,435.135,435.137,435.138, Section 6 of Public Law 99-643, and individuals eligible under 42 CFR 435.145 and 435.227.  
435.110,435.116,435.118

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (*select one*):**

- The following standard included under the State plan**

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

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

- The following dollar amount

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

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

Specify:

- Other

Specify:



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

---

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

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

- The amount is determined using the following formula:**

*Specify:*

The state is using post-eligibility rules for the period between Jan 1st 2014 and Dec 21st 2018 as per section 2404 of the ACA.

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iii. **Allowance for the family (select one):**

---

- Not Applicable (see instructions)**  
 **AFDC need standard**  
 **Medically needy income standard**  
 **The following dollar amount:**

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

- The amount is determined using the following formula:**

*Specify:*

- Other**

*Specify:*



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

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

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 **The State does not establish reasonable limits.**  
 **The State establishes the following reasonable limits**

*Specify:*



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## Appendix B: Participant Access and Eligibility

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

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

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


---

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

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**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (4 of 7)**

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

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**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (5 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

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

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan**

*Select one:*

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

*(select one):*

- 300% of the SSI Federal Benefit Rate (FBR)**

- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

*Specify:*

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

- The following dollar amount**

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

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

*Specify:*

- Other**

*Specify:*

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

- Not Applicable**

- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

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

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

- SSI standard**  
 **Optional State supplement standard**  
 **Medically needy income standard**

- The following dollar amount:**

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

- The amount is determined using the following formula:**

*Specify:*

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

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**iii. Allowance for the family (select one):**

---

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

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

- The amount is determined using the following formula:**

*Specify:*

- Other**

*Specify:*



---

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

---

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

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

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

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

## Appendix B: Participant Access and Eligibility

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

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

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

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

*Specify formula:*

- Other**

*Specify:*

The maintenance needs allowance is equal to the individual's total income as determined under the post-

eligibility process which includes income that is placed in a miller trust.

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

Select one:

- Allowance is the same**  
 **Allowance is different.**

*Explanation of difference:*

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

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

Select one:

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

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

- i. **Minimum number of services.**

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

- ii. **Frequency of services.** The State requires (select one):

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

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

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

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By an entity under contract with the Medicaid agency.

Specify the entity:

- Other  
Specify:

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

Case managers employed by local public agencies collect, develop and submit evaluation materials and assessment information to a QIDP (Qualified Intellectual Disabilities Professional) in the Operating Agency's Regional Office, who makes the determination. The case manager is at minimum a person with specialized training and a four year college degree in an area that would meet requirements for QIDP. The QIDP in the Operating Agency's Regional Office makes the determination based, at minimum, on the information from a psychologist (psychological evaluation) and the case manager.

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

Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disabilities with an age of onset prior to age 18, and significant functional limitations in three of six areas of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press). If necessary to support a conclusive determination, an ABS will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

The same level of care evaluation form was used for both institutional and waiver services, but the information from which adaptive functioning scores were obtained differed. Adaptive functioning level for institutional (ICF/IID) eligibility was determined using the ABS. The ICAP domain scores were specifically modified by one of the authors of the ICAP to meet the requirements of Alabama's definition and to match the outcomes of the

ABS. The only difference between the two instruments is that the ABS does not use maladaptive behavior as a factor, and the ICAP does. The ICAP is used in determining some of the rates for waiver services, so for efficiency of administration, the State recognizes the ICAP for determining adaptive limitations unless there is a doubt that the person would be eligible in an ICF/IID due to the predominance of maladaptive behavior in a qualifying, but borderline, ICAP service score. Currently, the Department of Mental Health does not operate state funded ICF/IID.

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

Local public planning authorities, known as designated 310 agencies after the legislation authorizing their creation, officially represent each county of the State of Alabama. These local authorities are the designated points of application to the Department of Mental Health. The 310 agencies coordinate and submit applications for enrollment in the Medicaid HCBS Waiver for Persons with Intellectual Disabilities to one of the five regional community services offices of the DMH (Operating Agency).

A QIDP in the RCS office reviews the results of all test and assessment information provided with the application and determines the eligibility of all individuals seeking waiver services.

The information needed to determine a person's eligibility for the waiver includes the Level of Care Evaluation (based on full scale IQ, the age of onset, and an ICAP functional assessment). In addition, medical and social information is submitted, and a criticality assessment is submitted and entered into a data base which ranks the individual on a waiting list. If the submitted test/assessment information is not complete or is inconclusive regarding the type or level of disabilities of the individual, the RCS office QIDP will request additional tests/assessments. Notification of need for additional tests, assessments or other information stops the level of care determination process until the additional information has been received.

Applicants who are determined eligible are placed on a waiting list, ranked by criticality of need and length of time waiting. When the person can be served from the waiting list, additional, different information must be submitted, including a Person Centered Plan of Care, a Summary of Habilitation and a signed Dissatisfaction of Services form to notify the applicant of his or her right to due process. Additional forms are required if the applicant is not already Medicaid eligible and is applying for a special income level or institutional deeming.

Annual re-determinations must include, along with the Person Centered Plan of Care and a Summary of Habilitation for the next year, information to re-determine the level of care:

- a. Written reference to and update of the original psychological evaluation which documented the applicant's intellectual disabilities or of a more recent full assessment, all documents to be kept on file and produced if requested.
  - b. An update of the adaptive behavior evaluation that was administered within the previous 24 months. ICAPs will not need to be re-administered if nothing about the functioning level has changed.
  - c. An annual medical report must be on file.
  - d. A social summary updated within 90 days of re-determination.
- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months
- Other schedule

*Specify the other schedule:*

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

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

*Specify the qualifications:*

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

The RCS office of the Operating Agency, once appropriate documentation is approved, submits the Waiver application packet to Central Office. Central Office will submit the information electronically to the AL Medicaid's fiscal intermediary to register the person in the long-term care system as a recipient of Waiver services and retrieve the enrollment dates. This registration is good for 12 full months, but then has to be resubmitted. Without the electronic resubmission and registration, claims for subsequent service dates will fail. Likewise the Plan of Care is for 12 months, and case managers know when they have to submit redetermination packets and assist consumers to remain eligible for Medicaid.

In order to assist the case managers the Division has design several prompts in the information system that will remind a case manager of a pending redetermination. First, the information system is designed to electronically prompt the case manager, known as a "tickler", when there is a redetermination due. The tickler system is set up to generate a redetermination notification, which launches 330 days after the previous redetermination or initial application, and appears is under Tasks on the home page. Additionally, there are two reports that the case manager, case manager supervisor, and the RCS office staff can run, filtered by enrollment start and end dates, which will list all the people that should be redetermined during the specified dates or people that are overdue. The first report, Redeterminations Due, will list all people that need to be redetermined within the report dates based on the Waiver enrollment dates. We encourage case managers to run this report 90, 60, or 45 days in advance. The second report, Redeterminations Overdue, works the same way but presents a list of people that have not been redetermined and should have been based on enrollment dates. This report will give the Division the ability to track overdue redeterminations in a more efficient manner and follow-up as needed. There are times when redeterminations are delayed for documentation purposes but in the event that someone failed to complete a redetermination on time this report will capture that information.

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

Records are maintained by the case management agencies and also by the Operating Agency's Regional Offices.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of applicants who received an evaluation for level of care that indicates a need for institutional care prior to being enrolled and receiving services. Percent equals the number of applicants who received an evaluation prior to enrollment divided by the total number of applicants.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**All waiver enrollments (both initial and re-determination) are submitted to Central Office for processing. Each enrollment packet will have a signed Level of Care prior to being enrolled.**

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

**Data Aggregation and Analysis:**

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

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of new enrollee Level of Care determinations made where the LOC criteria was accurately applied in accordance to state policy and procedure. Percent equals the number of accurate LOC determinations for new enrollees divided by the total number of new participants enrolled.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

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

**Data Aggregation and Analysis:**

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

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

**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.

Problems regarding individual participants' initial Level of Care are currently handled on an individual basis by RCS office staff of the operating agency. Resolution of these problems requires manual intervention. 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 RCS office has designated staff trained to review all supporting documentation that feeds into the Level of Care form. 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 those responsible for the discovered areas of weakness.
- b. When data shows consistent problems over two consecutive quarters, technical assistance / training will be provided to those at the point of weakness.
- c. If no improvement is seen in the next quarter after the intervention, a plan of correction will be required.

- ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**
- Yes**

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

## Appendix B: Participant Access and Eligibility

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### B-7: Freedom of Choice

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

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

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

1. Freedom of Choice: being informed of feasible alternatives under the waiver.

As part of assessment and service coordination, consumers and/or responsible parties are provided with adequate information to make an informed decision regarding community based care. This process frequently includes visits to programs and facilities and meetings with multiple providers in the area. Service coordination addresses problems and presents feasible solutions. Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

2. Freedom of Choice: being given the choice of either institutional or home and community based services.

Each person served through the waiver must make a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the plan of care form and has no legal or responsible party who can sign. In such a case, the case manager must document the reason(s) for absence of a signed choice and efforts made to locate a responsible party who could have signed for the person.

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

Records are maintained by the case management agencies and also by the Operating Agency's Regional Offices.

## Appendix B: Participant Access and Eligibility

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

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

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanic is the only significant Limited English Proficiency population in the State of Alabama at 4.1%.

## Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Day Habilitation
Statutory Service	Employment Support
Statutory Service	Personal Care
Statutory Service	Prevocational Services
Statutory Service	Respite
Other Service	Benefits and Career Counseling
Other Service	Community Experience
Other Service	Community Specialist Services
Other Service	Crisis Intervention
Other Service	Environmental Accessibility Adaptations
Other Service	Housing Stabilization Service
Other Service	Individual Directed Goods and Services
Other Service	Occupational Therapy
Other Service	Personal Emergency Response System
Other Service	Physical Therapy
Other Service	Positive Behavior Support
Other Service	Residential Habilitation Other Living Arrangement (OLA)
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment
Other Service	Specialized Medical Supplies
Other Service	Speech and Language Therapy
Other Service	Supported Employment Emergency Transportation

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

**Service:**

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**

	▼
<b>Category 4:</b>	<b>Sub-Category 4:</b>
	▼

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

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

**Service Definition (Scope):**

Day habilitation includes planning, training, coordination and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

Four levels of Day Habilitation have been identified, based on participant characteristics and the staffing ratios needed to support persons with those characteristics. There is a rate for each level.

Level one day habilitation is for consumers whose ICAP service score is 61 to 99.

Level two day habilitation is for consumers whose ICAP service score is 36 to 60.

Level three day habilitation is for consumers whose ICAP service score is 1 to 35.

Level four day habilitation is for consumers who need one to one support more than 75% of the time during service.

Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. For each consumer whom the day program transports between his residence and the day program, when his residence is more than 10 miles as measured in a straight radius from the day program site, an additional payment is available per day of transport.

The unit of service is 15 minutes.

Effective October 1, 2015 the Division of DD will eliminate the Partial Day Habilitation service as it will be duplicative and to date there are very few users. The new Day Habilitation 15 minutes unit will create flexibility needed to accommodate anyone that would like to spend a portion of their day utilizing this service.

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

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Day Habilitation services. Standards are in Alabama Administrative Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Day Habilitation services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;  
Geographical area served;  
Range of services provided; and  
Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or person centered plan (PCP).

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Day Habilitation Program

## Appendix C: Participant Services

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

**Service Type:** Statutory Service  
**Service Name:** Day Habilitation

**Provider Category:**

Agency ▼

**Provider Type:**

Certified Day Habilitation Program

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

Day Habilitation training services will be delivered by a habilitation aide and supervised by a Qualified Intellectual Disabilities Professional (QIDP) in coordination with the individual's person centered plan. The Aide will work under supervision and direction of a Qualified Intellectual Disabilities Professional. The QIDP must provide and document supervision of, training for, and evaluation of Aide in the individual client record. The QIDP must assist the Aide as necessary as they provide individual Habilitation services as outlined by the person centered plan.

Minimum Qualifications:

Must be 18 years of age and must possess a high school diploma or G.E.D.

**Training Requirements:**

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH which will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of intellectual and developmental disabilities.
3. Concepts of human development.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.

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

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service ▼

**Service:**

Supported Employment ▼

**Alternate Service Title (if any):**

Employment Support

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

03 Supported Employment	03021 ongoing supported employment, individual
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**Category 2:****Sub-Category 2:**

03 Supported Employment	03022 ongoing supported employment, group
-------------------------	---

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

03 Supported Employment	03010 job development
-------------------------	-----------------------

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

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

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

**Service Definition (Scope):**

There are two variations of Supported Employment covered within this waiver: 1) Small Group and 2) Individual. The first, which has been a service in this waiver for many years, is Employment Small Group. It most often consists of groups of individuals being supported in enclave or mobile work crew activities. This is reimbursed per 15 minutes unit of service. The second, which was approved by CMS in a previous amendment, is Employment Individual. The Employment Individual includes two distinct services: Job Developer and Job Coach and is reimbursed per 15 minutes unit of service. Both services must be provided in integrated settings and paid at minimum wage (or better).

Employment Small Group are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers. Employment Small Group services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and community-based individual employment for which the compensation is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment (both group and individual) services do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace.

Transportation accommodations to the worksite or supported employment provider's home-base should be a component of the planning process and integrated into the person centered plan. While developing the plan which will reflect employment goals; transportation issues, concerns, and access should be addressed. All avenues of possible sources of transportation should be considered including public transportation and natural supports such as family. If training is needed in order for a person to access transportation then that training should be outlined in the plan. The Supported Employment Emergency Transportation waiver service can be authorized, under special circumstances, intended to be limited in scope, duration, and not to exceed the annual cap.

Employment Individual services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. The two procedure codes under this heading are specifically intended to support the provision of supported employment at competitive wages in an integrated worksite: Job Coach and Job Developer. These are different roles and are performed, normally, by different staff. However, some providers may choose to utilize one staff to perform the two distinct services so long as documentation supports the differing activities. The provider agency must also have a QIDP.

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

The following limitation (A) applies to both (Supported) Employment Small Group and Individual services. Additional limitations regarding (Supported) Employment Individual are listed in (B) below.

(A) Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

(B) Limits and expectations specific to the Individualized Supported Employment Service.

Overlap with current service programs

The Individualized Job Coach and Employment Small Group cannot overlap traditional services; these services cannot be provided during the same hours of the day as Day Habilitation or Prevocational Habilitation.

The Individualized Job Developer can overlap traditional services, up to the maximum 40 hours per year.

Expectations and Outcomes:

Once a comprehensive vocational assessment (situational assessment and/or Discovery) is complete, the job development should begin with job placement as expected outcome.

Providers must expect to submit reports requested and designed by the DMH/DDD (and the Alabama Medicaid Agency and CMS, should the requests be made). Reports will support the measurement of outcomes.

It is expected that the job coach will fade his or her support as the individual becomes more integrated into the employer's workforce. Also, personal care on worksite can be used to supplant some of the job coach's faded hours. Therefore it is anticipated the 25 hours per week will be reduced to 15 hours per week after 4 months, and to 8 hours per week after 8 months.

Thus, the maximum hours for an individual will be presumed to be 836 per year (109/month for 4 months; 65/month for 4 months; 35/month for 4 months).

Job Developer will be limited to 40 hours per year.

An employment plan is required initially, and subsequent updates can request modifications to the above limitations. Detailed explanation and rationale will be required.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Day Habilitation Program
Agency	Certified Waiver Hourly Service Provider

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Employment Support**

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**Provider Category:**Agency **Provider Type:**

Certified Day Habilitation Program

**Provider Qualifications****License** (*specify*):

**Certificate** (*specify*):

Alabama Administrative Code Chapters 580 - 3 - 23 and 580 - 5 - 30 A/B

**Other Standard** (*specify*):

Supported Employment (Small Group) providers must meet the same standards as the Day Habilitation provider. The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Supported Employment services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B. There are base standards for the traditional, per diem reimbursed model listed at (A) below; additional or modified requirements apply for the Individualized Supported Employment model and are listed under the Provider Type Certified Hourly Supports Program.

(A) An applicant wishing to provide these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certification certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Supported Employment services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;  
 Geographical area served;  
 Range of services provided; and  
 Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or individual activity plan (IAP).

In addition to certification, the following requirements apply to the provider's staff.

Small Group personnel will meet the same requirements as basic direct care staff:

**Qualifications:**

High School diploma or equivalent

Minimum 1 year experience working with persons with ID

Background check; drug testing.

Training in career development planning and vocational assessment, in addition to what the DMH/DDD standards require.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Employment Support****Provider Category:**

Agency ▾

**Provider Type:**

Certified Waiver Hourly Service Provider

**Provider Qualifications****License (specify):****Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard (specify):**

Supported Employment (Individual) Service Provider Qualifications

Job Coach and Job Developer workers may be employed by, or under contract with, any agency that qualifies to provide hourly services under the waiver. Any agency or individual undertaking the provider on this service must employ or contract with a QIDP to provide the required supervision and must meet the other requirements in this addendum related to training, plans of care, documentation, and reporting. The primary requirements for the provider agency are to:

- a) Handle all payroll taxes required by law
- b) Provide training and supervision as required by this scope of services
- c) Maintain records to assure the worker was qualified, the service was provided, and provided in accordance with the plan of care
- d) Implement a plan and method for providing backup at any time it is needed
- e) Implement and assure the person and his or her family are and remain satisfied with the service

Supported Employment Individual: Job Coach

The minimal requirement for this position is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree, preferable with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

The Job Developer, in addition to the Job Coach Qualifications, will complete a minimum of one certificate based job development and placement curriculum. The Supported Employment Coordinator for the Division of Developmental Disabilities will provide an approved listing of such curriculums.

**Benefits and Limitations**

Job Coach hours must be flexible in order to meet needs as they arise.

Individuals who are more capable may need less support over the long term, while individuals who are less capable may need more support, but work fewer hours, so a round estimate of 25 hours per week will serve as a maximum starting authorization.

Furthermore, it is expected that the job coach will fade his or her support as the individual becomes more integrated into the employer's workforce. Also, personal care on worksite can be used to supplant some of the job coach's faded hours. Therefore it is anticipated the 25 hours per week will be reduced to

15 hours per week after 4 months, and to 8 hours per week after 8 months.

Thus, the maximum hours for an individual will be presumed to be 836 per year (109/month for 4 months; 65/month for 4 months; 35/month for 4 months).

An employment addendum is required as part of the person centered plan, and subsequent updates can request modifications to the above limitations. Detailed explanation and rationale will be required.

#### Job Specification:

The Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of individuals involved in Supported Employment. The Job Coach works under the direction of a QIDP.

The specific duties of the Job Coach include:

- a. Training of individuals in supported work to perform specific jobs consistent with their abilities;
- b. Working with employers to modify or adapt job duties or work stations so individuals in supported work can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client;
- c. Teaching individuals associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;
- d. Assisting each individual placed in a job-training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the individual worker or other employees to communicate with each other, or the provision of disability awareness training to workers of the company;
- e. Working with individual to be placed in employment and/or with family or service provider to insure that the individual has reliable transportation to and from work, adequate housing, and emotional support for his or her job efforts;
- f. Making every effort to insure that the individual in supported work and the job are appropriately matched through comprehensive vocational assessment (Situational Assessment and/or Discovery) prior to job placement. Part of the assessment may include reviewing current progress notes in individual's present placement, studying referral information, and working with the individual to assess work skills;
- g. Communicating through written and oral reports on progress of individual's in supported work to Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);
- h. Providing continued ongoing support to individual's in supported work;
- i. Performing other job duties necessary to ensure the success of individual's in supported work as well as any additional tasks assigned by the Program Director that will be of benefit to other individuals in the program.

#### Individualized Job Coach: Scope of Service

- a. Performing a vocational assessment such as Situational Assessment or Discovery (prior to job development) which will be utilized for job development and placement.
- b. Development of plan for employment as part of the person centered planning process but with distinct employment outcomes.
- c. On the job training and skill development
- d. Co-worker training (for accommodations and natural supports)
- e. Facilitating job accommodations and use of assistive technology
- f. Job site analysis (matching job site needs with needs of the person), job carving
- g. Educating the person and others on the job site regarding rights and responsibilities and the role of self-advocacy in the work place.
- h. Participation with the interdisciplinary team to support the person to achieve chosen employment outcomes.
- i. Facilitate transportation arrangements with team.
- j. Documentation: progress on training goals and documentation of training; progress notes on a per day basis rather than a per unit basis.

#### Individualized Job Developer: Scope of Service

- a. Marketing the service and person's skills

- b. Employer Negotiation
- c. Job Structuring (negotiating hours or location to meet the abilities of the person)
- d. Job Carving
- e. Placement: once placement is arranged, the job coach enters, and there may be a cross-over (transfer) period of up to 5 hours.

The supported employment provider agency should also have a QIDP, and among the functions of the QIDP is benefit coordination and management.

**Training Requirements:**

The training program for Supported Employment personnel will reinforce the responsibility to insure successful employment of recipients involved in supported employment. The personnel must be certified by a QIDP as having completed training approved by DMH/DDD. This certification must be documented and is subject to review by DMH/DDD and Alabama Medicaid. Minimum training requirements shall include the following areas:

- a. Overview of intellectual and developmental disabilities
- b. Skills to identify recipient abuse, neglect and mistreatment and reporting procedures
- c. Recipient rights and grievance procedures
- d. Oral and written instructions regarding care plan
- e. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

Ongoing training will be conducted as needed but at least annually for training requirements b and c above.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

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

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


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

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

**Service Definition (Scope):**

Personal Care Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Personal Care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate code for this service, provided at the worksite, to distinguish it from other personal care activities, effective in Fiscal Year 2008.

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported. The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer. This service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

Personal care under the waiver may also include general supervision and protective oversight reasonable to accomplishing of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual. A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Developmental Disabilities and be subject to review by the Single State Agency for Medicaid.

While in general personal care will not be approved for a person living in a group home or other residential setting, the Division of Developmental Disabilities may approve it for specific purposes that are not duplicative.

Separate Definition for Self Directed Personal Care Follows...  
Self-Directed Personal Care Services

This definition of Personal Care Services is intended to allow participants and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers. The workers will be paid by a fiscal intermediary, also known as a FMSA (Financial Management Service Agency).

The definition of Self-Directed Personal Care Services includes assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Self-Directed Personal Care may also include general supervision and protective oversight reasonable to ensure the health, safety and inclusion of the client. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service.

Self-Directed Personal Care may include supporting the participant at an integrated worksite where the participant is paid a competitive wage. There is not a separate rate or service code for this support when it is self directed.

Self-Directed personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. Additional payment will be made to the worker for mileage. The attendant must have a valid Alabama driver's license and insurance coverage as required by State law. This service may provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency transportation program. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Consumers and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers.

There is no restriction on the place of service as long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15-minute unit of service delivered to the individual, and does not include the worker's time of travel to and from the place of work.

Self-Directed Personal Care may not be provided to participant's who lack the necessary support systems to ensure the responsibilities of employing staff are carried out and that the participant's security and well-being is maintained. Thus, this service would typically be provided to participants who live in their own homes with family members or other responsible relatives who can assist with the responsibilities of administering a self-directed services program. Self-Directed Personal Care may also be provided in settings where the individual lives in his own house or apartment alone or with others, with the assistance of family or a circle of support, but the Regional Community Service Office must review and approve this arrangement before it can be reimbursed. The purpose of this review is to assure the support is near and frequent enough to carry out the needed tasks and also to assure there is no conflict of interest.

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

The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Parents and other caretakers shall be key informers on the matter of special training, and will be encouraged to participate in the training and supervision of the worker.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15-minute unit of service delivered to the individual, not including worker's time of travel to and from the place of work.

Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor may they be legally obligated in any other way to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

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

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

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

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Waiver Hourly Services Provider
Individual	Self-Directed Personal Care Worker

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Personal Care**

**Provider Category:**

Agency ▼

**Provider Type:**

Certified Waiver Hourly Services Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

Personal Care Services Provider Qualifications

Personal care workers may be employed by, or under contract with, any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QIDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting. The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law
- Provide training and supervision as required by this scope of services
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care

- e) Implement a plan and method for providing backup at any time it is needed
- f) Implement and assure the person and his or her family are and remain satisfied with the service

#### Personal Care Workers:

- a) Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency
- b) Must have background checks required by law and regulation
- c) Must be at least 18 years of age
- d) Must be able to read and write and follow instructions
- e) Must have at least completed tenth grade
- f) Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition
- g) Must have no physical or mental impairment that would prevent providing the needed assistance to the person
- h) If providing transportation, must have valid driver's license and insurance as required by State Law

Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor shall they be in any other way legally obligated to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

#### Training Requirements

This service is intended to promote self-determination of waiver participants. To the extent practical, safe and cost effective, the individual and his family are encouraged to exert choice in planning, and in the selection and hiring of staff, and are encouraged to provide training and supervision to the worker (s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker including following the Personal Care Plan of Care, the rights and responsibilities of the provider and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the provider agency or regional office.

- a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
- b) Training in CPR and first aid and, if administration of ordinarily self-administered medication is required by the consumer, training in medication administration. As needed due to challenging behavior by the consumer, the worker will also be trained in behavioral intervention techniques appropriate to the consumer. Training in medication administration and behavior intervention techniques may be waived if not required to support the person.
- c) Training in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
- d) Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the consumer and identified by the planning team.
- e) The provider will maintain a record of training.

#### Supervision

A QIDP must visit the person, in person, at least every 90 days. The planning team shall recommend a visit schedule in the personal care addendum. The visiting QIDP shall make an assessment of the effectiveness of the service, the consumer satisfaction with the service, and of any changes that may

need to be made, including additional training or a change in the plan of care. This record shall be shared with the provider agency and the individual and his or her family.

#### Documentation

The direct service provider and/or billing provider must maintain documentation of the dates and hours of service provided, and of the service activities provided within each span of work, showing that services delivered are consistent with the recipient's plan of care. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer and the consumer's Medicaid number, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the specific activities provided within each span of work, will be acceptable as a minimum. In addition, there must be evidence of a quarterly review by a QIDP, of the services provided and of the continued appropriateness of those services.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DMH Certification Surveyors

##### Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Personal Care**

#### Provider Category:

Individual 

#### Provider Type:

Self-Directed Personal Care Worker

#### Provider Qualifications

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Self-Directed Personal Care Workers:

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

#### Training Requirements

This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s).

Basic elements of training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker including following the Plan of Care,

the rights and responsibilities of the worker and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and regional office. In addition and as needed, training in the following areas will be provided by the family or others and recorded.

- Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
- If administration of ordinarily self-administered medication is required by the consumer, training and ongoing supervision in medication administration.
- Training as needed in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the consumer and identified by the plan of care.

#### Supervision

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

#### Documentation

The family and consumer must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly for processing billing to Medicaid and payment to the workers. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Self-Directed Personal Care Services Financial Management Services

The self-directed personal care workers will be employed by the family and consumer, who will be employers of record. The family and consumer will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the personal care workers employed by the family and consumer, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per personal care worker, which will document the hours the worker has worked during the bi-weekly pay period.

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:

- Handle all payroll taxes required by law
- Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
- Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
- Furnish background checks on prospective employees
- Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency and the consultant and the case manager. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
- Establish savings accounts for which any dollars saved between authorized services and the employer on records wage negotiations would be available for Individual Directed Goods and Services upon approval.

- Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service.

**Frequency of Verification:**

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

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service ▼

**Service:**

Prevocational Services ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

04 Day Services

04010 prevocational services ▼

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

▼

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

▼

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

▼

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

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

**Service Definition (Scope):**

Prevocational habilitation, an hour unit service under the Waiver, must not be available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services under the Waiver are designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Services include teaching such concepts as attendance, task completion, problem solving, interpersonal relations and safety, as outlined in the individual's person-centered plan. Prevocational

services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a two year period, with employment (integrated and competitive salary/wage) being the specific outcome. It is expected that after two years a referral will have been made to AL Vocational Rehabilitation Services to begin the Milestones program for job placement and short term follow up or the individual would utilize the individual employment service options in the waiver (with prior approval). If after two years a person has not been referred to AVRS or moved into other waiver services, the provider must justify continuing this service to the Central Office Supported Employment Coordinator.

Individuals receiving prevocational services must have employment-related goals in their person-centered plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services. Transportation and how it will be obtained should be part of the planning process.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services under the waiver.

Vocational services, which are not covered through the waivers, are services that teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and are not delivered in an integrated work setting through supported employment. This differs from prevocational services in that prevocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. These goals should be described in the individual's person-centered plan.

Limitations:

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

#### Other Standards

An applicant wishing to provide these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Prevocational services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;

Geographical area served;

Range of services provided; and

Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or individual plan of care.

In addition to certification, the following requirements apply to the provider's staff:

**Activity Program Aide: Job Specifications**

The minimum requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, pre-vocational education, psychology or a related field is preferred along with experience supervising or training and knowledge of persons with disabilities.

**Specific Duties:** The Activity Program Aide will work under the supervision and direction of a QIDP. The QIDP will provide and document on-site supervision every 30 days. Supervisor reports must be maintained in the personnel file and are subject to review by DMH/DDD and the Alabama Medicaid Agency.

The duties of the Activity Program Aide (Pre-Vocational) include:

1. Instructs/demonstrates/interacts with clients concerning a variety of education, personal care, pre-vocational training, job safety, and social behaviors, in accordance with the individual's habilitation plan and program requirements. Uses sound judgment and abides by supervisor's instructions, minimum standards and other applicable regulatory standards in order to foster client self-sufficiency and independence.
2. Converses with/listens to clients concerning personal needs, responsibilities, expectations, aspirations, privileges, and personal/behavioral problems in a supportive and understanding manner.
3. Participates in developing, modifying, and adapting instruction and training to individual client needs.
4. Interacts often and appropriately with clients using both verbal and nonverbal methods (gestures, modeling, sign language, etc.) to provide information to clients about expected behavior, duties, and activities.
5. Observes the quality of production and integrates efficiency concepts in the work process.
6. Provides/receives information to/from peers, supervisors, other professional staff, support personnel, and clients pertaining to care plan, schedules, programs, and progress using personal contacts, meetings, memorandums, reports, records and filing systems in accordance with established schedules in order to facilitate client training, record maintenance and the exchange of other pertinent information.
7. Assists in computing data for programs such as behavior management, speech, token reinforcement, vocational, and social in order to assess client progress.

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

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Prevocational Program

## Appendix C: Participant Services

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

**Service Type:** Statutory Service

**Service Name:** Prevocational Services

**Provider Category:**

Agency ▼

**Provider Type:**

Certified Prevocational Program

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

An applicant wishing to provide these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Prevocational services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;  
 Geographical area served;  
 Range of services provided; and  
 Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or plan of care.

In addition to certification, the following requirements apply to the provider's staff:

**Activity Program Aide: Job Specifications**

The minimum requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, pre-vocational education, psychology or a related field is preferred along with experience supervising or training and knowledge of persons with disabilities.

**Specific Duties:** The Activity Program Aide will work under the supervision and direction of a QIDP. The QIDP will provide and document on-site supervision every 30 days. Supervisor reports must be maintained in the personnel file and are subject to review by DMH/DDD and the Alabama Medicaid Agency.

The duties of the Activity Program Aide (Pre-Vocational) include:

1. Instructs/demonstrates/interacts with clients concerning a variety of education, personal care, pre-vocational training, job safety, and social behaviors, in accordance with the individual's assessed needs and plan requirements. Uses sound judgment and abides by supervisor's instructions, minimum standards and other applicable regulatory standards in order to foster client self-sufficiency and independence.
2. Converses with/listens to clients concerning personal needs, responsibilities, expectations, aspirations, privileges, and personal/behavioral problems in a supportive and understanding manner.
3. Participates in developing, modifying, and adapting instruction and training to individual client needs.
4. Interacts often and appropriately with clients using both verbal and nonverbal methods (gestures,

modeling, sign language, etc.) to provide information to clients about expected behavior, duties, and activities.

5. Observes the quality of production and integrates efficiency concepts in the work process.
6. Provides/receives information to/from peers, supervisors, other professional staff, support personnel, and clients pertaining to care plan, schedules, programs, and progress using personal contacts, meetings, memorandums, reports, records and filing systems in accordance with established schedules in order to facilitate client training, record maintenance and the exchange of other pertinent information.
7. Assists in computing data for programs such as behavior management, speech, token reinforcement, vocational, and social in order to assess client progress.

#### Training Requirements

The Activity Program Aide (Pre-Vocational) training should demonstrate interaction with recipients concerning education, personal care, pre-vocational training, job safety and social behaviors, in accordance with the recipient's habilitation plan and care plan. The minimum training requirements:

1. Planning and coordinating all activities according to the individual habilitation and care plan.
2. Leadership with recipients doing therapeutic or rehabilitative activities programs.
3. Conferring with other professional personnel concerning the progress and needs of the recipients.
4. Providing individual instruction when needed.
5. Health observation including hygiene medication control/universal precautions.
6. Recipient abuse, neglect and mistreatment.
7. Knowledge of equipment and supplies needed for assigned activities.
8. Recipients rights and grievance procedures.
9. CPR first aid, medical emergencies.
10. Training on how to read and comprehend written materials, such as the care plan, habilitation plans and policy and procedures manuals.

Ongoing training will be conducted as needed but at least annually for above training requirements 6 and 8.

#### Additional Provider Requirements

The provider of service

- a) Must have required training prior to providing service;
- b) Must keep record of required training in the personnel folder; and
- c) Must maintain a service log that documents specific days on which services were delivered consistent with the recipient's individual plan of care.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DMH/DDD Certification Surveyors

##### Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Statutory Service ▼

#### Service:

Respite ▼

#### Alternate Service Title (if any):

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

09 Caregiver Support	09011 respite, out-of-home	▼
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**Category 2:****Sub-Category 2:**

09 Caregiver Support	09012 respite, in-home	▼
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**Category 3:****Sub-Category 3:**

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

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

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

**Service Definition (Scope):**

Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.

Respite is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. As crisis relief, out of home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in his home, or if necessary, to locate another home for him.

Some consumers are institutionalized because their community supports become exhausted, or because they don't know how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible. The goal is to avoid institutionalization.

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

Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Developmental Disabilities, subject to review by the Alabama Medicaid Agency. The limitation on in home and out of home Respite Care in combination shall be 4320 15-minute units of service (equals 1080 hours or 45 days) per participant per waiver year.

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

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

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

- Legally Responsible Person**

- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Residential Facility
Agency	Certified Waiver Hourly Services Provider (for In-Home Respite)

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Community Residential Facility

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Certified Waiver Hourly Services Provider (for In-Home Respite)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Alabama Administrative Code Chapters 580-3-23 and 580-530A/B

**Other Standard (specify):**

Documentation

The billing provider must maintain documentation of the services provided each day. Logs signed by the worker and cosigned by the consumer or family member are acceptable.

### Respite Care Provider Qualifications

Respite care workers may be employed by any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QDDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law
- Provide training and supervision as required by this scope of services
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care
- Implement a plan and method for providing backup at any time it is needed
- Implement and assure the person and his or her family are and remain satisfied with the service

Respite Care Workers:

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

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DMH/DDD Certification Surveyors

##### Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Other Service 

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

#### Service Title:

Benefits and Career Counseling

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

03 Supported Employment

03030 career planning

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

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

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



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

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

**Service Definition (Scope):**

The Benefits and Career Counseling service is designed to assist people and family member(s) with respect to waiver services and employment. The Benefits and Career Counselor provides intensive work incentive counseling services to beneficiaries of SSDI/recipients of SSI.

The Counselor must be a certified Work Incentives Counselor (CWIC) through the Social Security Administration. The Counselor will receive beneficiary referrals from the primary Information & Referral Triage CWIC based on the beneficiary county of residence. If I&R services alone are insufficient, beneficiaries are referred to the regional Benefits Counselor serving the county of residence. Once referred to the regional CWIC/Benefits and Career Counselor, a case file is established and maintained complying with project documentation guidelines. Based on the identified needs, an array of benefits counseling and work incentive services will be developed, provided, and documented. These services may include but are not limited to: Intensive benefits counseling, Benefits Summary & Analysis, Work Incentive Plan, Ongoing Benefits Planning & documentation of those services. The Benefits and Career Counselors consult with their team members (other CWICs serving various locations statewide and ADRS SSA Specialist), local and state SSA staff, Virginia Commonwealth University (VCU) technical assistance team members, workforce development staff, and other human services personnel, and recommends, and facilitates use of work incentives to support beneficiary's employment choices. The Benefits Counselors will enter and maintain data collection according to project requirements. Documentation of services provided and collaborative efforts between the Benefits Counselors and the Information & Referral CWIC Counselor is communicated via the AL Department of Rehabilitation Services (ADRS) case management system (SMILE).

The Benefits and Career Counselors will function as technical assistance resources to case management agencies, waiver services providers, regional offices, as well as individuals and family/caretaker in their assigned area. The Counselors will work to discover and develop information about community resources, networks, advocacy groups and non-profit providers and will utilize these community resources to assist waiver participants and their support team with implementing work incentives. Benefits and Career Counselors may be required to develop and conduct community work incentive seminars, workshops, or other outreach, education or training activities in order to present information to individuals or professional organizations regarding work incentives and the services provided through this services.

These positions require proactive, well organized professionals who work well independently and as effective team members. The Benefits and Career Counselors must have the ability to manage multiple high priority tasks, possess and use excellent time management skills and have good verbal and written communication skills.

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

The individual(s) must be a Certified Work Incentives Counselor (CWIC) through the Social Security Administration. Participation in Part One of the competency-based Work Incentives Counseling community partner assessment and certification process. Part One of the Work Incentives Counseling Certification process takes place in the 6-week period immediately following completion of the initial training session and involves completing a series of online competency based assessments. The assessment process takes, on average, 25-45

hours of time over the 6-week period. Participants should plan to budget their time accordingly. Successful completion of all assessments during this 6-week period results in Provisional Community Partner Work Incentives Counseling Certification. In order to be fully certified a Counselor must develop benefit analysis for a person receiving SSI, SSDI, and both SSI and SSDI. If the analysis is correct then the Counselor is certified to provide this waiver service with no limit to amount, frequency, or duration.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	DMH or DVRS Certified Work Incentives Counselor

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Benefits and Career Counseling

**Provider Category:**

Agency ▼

**Provider Type:**

DMH or DVRS Certified Work Incentives Counselor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

The individual(s) must be a Certified Work Incentives Counselor (CWIC) through the Social Security Administration. This includes a Level 5 security clearance from Social Security Administration/Department of Homeland Security due to Personally Identifiable Information (PII).

**Other Standard** (*specify*):

Benefits and Career Counselors are housed in each of the Division of Developmental Disabilities five regional offices but will be under the AL Department of Rehabilitation Services (ADRS) supervision by the SSA Specialist in the ADRS State Office.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AL Department of Mental Health

AL Department of Rehabilitation Services

**Frequency of Verification:**

As needed to remain certified per the Social Security Administration.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Community Experience

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

04 Day Services

04070 community integration ▼

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

▼

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

▼

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

▼

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

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

**Service Definition (Scope):**

Community Experience has three distinct categories: Individual, Group, and Self-Directed. Community Experience services are non-work related activities that are customized to the individual(s) desires to access and experience community participation. Community Experience is provided outside of the person's residence and can be provided during the day, evening, or weekends. The intent of this service is to engage in activities that will allow the person to either acquire new adaptive skills or support the person in utilizing adaptive skills in order to become actively involved in their community.

Community Experience Individual services are provided to an individual participant, with a one-to-one staff to participant ratio which is determined necessary through functional and health risk assessments (ICAP and HRST) prior to approval. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval. Community Experience Group services are provided to groups of participants, with a staff to participant ratio of one to two or more, but no greater than four (4) participants.

CEI and CEG services are directly linked to goals and expectations identified in the person centered plan. The intended outcome of these services is to improve access to the community through increased skills, increased natural supports, and/or less paid supports. CEI and CEG services are designed to be teaching and coaching in nature. These services assist the participant in acquiring, retaining, or improving socialization and networking, independent use of community resources, and community participation outside the place of residence. CEI and CEG services are not facility-based.

Community Experience Self Directed service is for individuals who choose (and are approved) to self direct

services and would otherwise need day supports and services (i.e. day habilitation) to obtain identified goals. Again, the intent of this service is to engage in activities that will allow the person to either acquire new adaptive skills or support the person in utilizing adaptive skills in order to become actively involved in their community. CE Self Directed services are not facility-based.

Transportation to and from activities and settings is a component of this service. Transportation is provided by the agency responsible for the service or by the self directed staff/family/or other natural support. Transportation provided through Community Experience Services is included in the cost of doing business and incorporated in the rate.

All Community Experience Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Community Access services must not duplicate or be provided at the same period of the day as Prevocational Service, Day Habilitation, Employment Small Group, or Job Coach and cannot be utilized if a person is receiving Residential Habilitation. Additionally, an individual serving as a representative for a waiver participant in self-directed services may not provide Community Experience services.

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

Community Experience services cannot be provided in the person's home or provided if a person is receiving Residential Habilitation. Additionally, Community Experience cannot overlap other Day Services including Pre-vocational, Day Habilitation, Employment Small Group, or Job Coach. Additionally, an individual serving as a representative for a waiver participant in self-directed services may not provide Community Experience services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Self Directed Community Experience employee
Agency	Certified Day Habilitation Program

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Community Experience

**Provider Category:**

Individual ▾

**Provider Type:**

Self Directed Community Experience employee

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

#### Self Directed Community Experience Workers:

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

#### Training Requirements

This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s).

Basic elements of training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the worker including following the Plan of Care, the rights and responsibilities of the worker and the participant, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and regional office. In addition and as needed, training in the following areas will be provided by the family or others and recorded.

- a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
- b) If administration of ordinarily self-administered medication is required by the participant, training and ongoing supervision in medication administration.
- c) Training as needed in communication skills; in understanding and respecting participant choice and direction; in respecting the participant's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.

#### Supervision

Supervision of the self-directed workers is the responsibility of the family and/or the participant.

#### Documentation

The family and participant must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly for processing billing to Medicaid and payment to the workers. Daily or weekly logs, signed by the worker and by the participant or family member, which identify the participant, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Financial Management Services

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

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the

FMSA are to:

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

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Community Experience**

---

**Provider Category:**

Agency 

**Provider Type:**

Certified Day Habilitation Program

**Provider Qualifications**

**License (specify):**



**Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 580-5-33.

**Other Standard (specify):**



**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Community Specialist Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

17 Other Services

17990 other ▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Community Specialist Services include professional observation and assessment, facilitation of person centered plan development and continuance, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes as needed to facilitate and implement the person centered plan. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. The community specialist will serve as both a qualified planner and, at the consumer's or family's request, a broker.

The community specialist must meet QDDP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist will assist the consumer and his caregivers to design and implement specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational skills, and behavior management.

These functions differ from case management in the skill level and independence of the specialist, as well as the focus on self-determination and advocacy for the individual. Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

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

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory. The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client's needs and

condition. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

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

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

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

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Individual employed or contracted by a certified agency
Individual	Qualified Individual Employed by a Self-Directing Participant or Family

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Specialist Services**

**Provider Category:**

Agency ▼

**Provider Type:**

Individual employed or contracted by a certified agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

The individual must meet federally defined QDDP qualifications (42 CFR 483.430) and be free of any conflict of interest. This means he or she cannot work for any provider agency from which a person assisted by this community specialist is receiving, or is likely to receive, services reimbursed through this waiver program.

In addition, the provider must have experience, verified by the DMH/DDD, in person centered planning. This will consist of both training and actual practice.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Specialist Services**

**Provider Category:**

Individual 

**Provider Type:**

Qualified Individual Employed by a Self-Directing Participant or Family

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 and 580-5-30

**Other Standard (specify):**

The individual must meet federally defined QDDP qualifications (42 CFR 483.430) and be free of any conflict of interest. This means he or she cannot work for any provider agency from which a person assisted by this community specialist is receiving, or is likely to receive, services reimbursed through this waiver program.

Note that a person may qualify as a community specialist and work for an agency, and also work for a participant or family who is self-directing, as long as there is no conflict of interest.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMSA (Financial Management Service Agency) will verify the qualifications prior to enrolling the community specialist. This verification need only be made initially. If the community specialist is also employed by an agency, and thus certified by the Operating Agency, the FMSA may accept the Operating Agency's verification of qualifications, but will need to verify the absence of conflict of interest itself.

**Frequency of Verification:**

Initial verification is all that is required unless the participant or family reports a change which might call the initial verification into question.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service 

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

**Service Title:**

Crisis Intervention

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

10 Other Mental Health and Behavioral Services	10030 crisis intervention
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**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with mental retardation are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises.

When the need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved, at least by phone followed up in writing, by the regional community service office of the DMH prior to the service being initiated.

Specific crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
- Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
- Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

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

Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting. There are two levels of staff, professional and technician.

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Waiver Provider or DMH/DDD (State Agency) Regional Team

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Crisis Intervention

Provider Category:

Agency ▼

Provider Type:

Certified Waiver Provider or DMH/DDD (State Agency) Regional Team

Provider Qualifications

License (specify):

Certificate (specify):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B, if the team is employed by a residential, day or hourly services provider.

Other Standard (specify):

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Alabama and meeting the requirements of a QDDP (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services. The team shall be mobile and prepared to provide direct staffing if that is necessary to implement the plan.

Crisis teams may be agency based (certified waiver residential and day habilitation providers, or DMH/DDD Regional Offices), or they may stand alone.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

## Environmental Accessibility Adaptations

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptation

**Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

**Service Definition (Scope):**

Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

The individual's home may be a house or an apartment that is owned, rented or leased. Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered. Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.

Payment is for the cost of material and labor. The unit of service would be the job. Total costs of environmental accessibility adaptations shall not exceed \$5,000 per year, per individual.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Self Directed Contractor
Agency	Contractor

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Accessibility Adaptations****Provider Category:**Agency **Provider Type:**

Self Directed Contractor

**Provider Qualifications****License (specify):**

Meets all applicable State (Alabama Code 230-X-1) and Local Licensure requirements.

**Certificate (specify):**


**Other Standard (specify):**

All construction, wiring, plumbing meets applicable building codes.

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

Alabama Licensing Board for General Contractors.

**Frequency of Verification:**

Annual

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Accessibility Adaptations****Provider Category:**Agency **Provider Type:**

Contractor

**Provider Qualifications****License (specify):**

Meets all applicable State (Alabama Code 230-X-1) and Local Licensure requirements.

**Certificate (specify):**


**Other Standard (specify):**

All construction, wiring, plumbing meets applicable building codes.

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

Alabama Licensing Board for General Contractors

**Frequency of Verification:**

Annually

### HCBS: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Housing Stabilization Service

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

16 Community Transition Services

16010 community transition services ▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

The Housing Stabilization Service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. Conducting a Housing Coordination and Stabilization Assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain housing (including accessing housing, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assisting participant with finding and securing housing as needed. This may include arranging or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitted applications, securing deposits, and locating furnishings.
4. Developing an individualized housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person Centered Plan. Identify short and long-term measurable goal(s), establishes short and long-term goals, establish how goals will be achieved and how concerns will be addressed, and identifies where other provider(s) or services may be needed in order to achieve the goal(s).
5. Participating in Person-Centered plan meetings at redetermination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized housing stabilization

portion). Identify any additional supports or services needed outside the scope of Housing Stabilization Services and address among the team.

7. Communicating with the landlord and/or property manager regarding the participant’s disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.

8. If at any time the participant’s housing is placed at risk (i.e., eviction, loss of roommate or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community based supports which includes locating new housing, sources of income, etc.

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

Housing Stabilization Service must be:

- a. Authorized and included in the participant's service plan;
- b. Necessary for the participant's safe transition to the community;
- c. Exclusive of expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transit

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	DMH Transition Services

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Housing Stabilization Service

**Provider Category:**

Agency ▼

**Provider Type:**

DMH Transition Services

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

This service provider must meet AL DMH Personnel requirements for Transition Services Coordination with a specialty in Housing Coordination.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AL Department of Mental Health

**Frequency of Verification:**

Verification of qualifications will be conducted once. There is no need to re-evaluate.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Individual Directed Goods and Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

17 Other Services

17010 goods and services ▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; the item or service is not illegal or otherwise prohibited by Federal and State statutes and regulations, and the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Goods and Services are required to meet the identified needs and outcomes in the individual's person centered plan, are the most cost effective to meeting the assessed need, assures health, safety, and welfare, and are directly beneficial to the individual in achieving at least one of the following outcomes: Improved cognitive, social, or behavioral functioning; maintain the individual's ability to remain in the community; enhance inclusion and family involvement; develop or help maintain personal, social, or physical skills; decrease dependency on formal supports services; increase independence.

Experimental or prohibited treatments are excluded, as well as room and board; items solely for entertainment of recreation; cigarettes and alcohol.

A prior approval is necessary before accessing this service. The process begins with the enrollment meeting between the person (and family if applicable) and the self directed liaison. The liaison will review all the employer on record paperwork and discuss the budgetary authority. During this meeting the person's budget will be discussed along with what is considered acceptable and not acceptable uses of this service. A list will be provided to the person (and family) indicating items that are strictly prohibited. It is also during this time that the person may identify items of interest. These items will be listed on the person's budget and submitted to the FMSA. The FMSA will follow their process of working with the individual on procurement and reimbursement, as well as adjust the person's budget accordingly. The FMSA will notify the Regional Office and self-directed liaison of the actual amount spent on Individual Directed Goods and Services on a monthly basis.

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

The limit on amount is determined individually based on the balance of the individual's savings account at the time of the request which is maintained by the Financial Management Services Agency, but not to exceed \$1000 annually. 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 waiver services the ability to access any dollars from the savings account and utilize this service will be terminated. Additionally, dollars not utilized in the current fiscal year will roll back to the Division of Developmental Disabilities. Dollars will not roll forward in a person's account for the next fiscal year.

Items, goods or services that are not for the primary benefit of the participant are prohibited. Items, goods or services that are unrelated to the person's assessed long-term support needs and outcomes related to those needs are prohibited.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Self Directed Vendor of Goods or Services (Family, friend, neighbor, supportive home care worker)
Agency	Home Health Care Agency or Other Merchants or Contractors

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Individual Directed Goods and Services**

**Provider Category:**

Individual ▾

**Provider Type:**

Self Directed Vendor of Goods or Services (Family, friend, neighbor, supportive home care worker)

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard (specify):**

Typical vendors in the community, according to the goods, services and supports needed. The person's experience/knowledge providing the good and/or service matches the good/service provided.

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

Self Directed Liaison  
Financial Management Services Agency (FMSA)

**Frequency of Verification:**

Annually or at the time of purchase

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Individual Directed Goods and Services**

**Provider Category:**

Agency ▾

**Provider Type:**

Home Health Care Agency or Other Merchants or Contractors

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 and 580-5-33.

**Other Standard (specify):**

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

Typical vendors in the community, according to the goods, services and supports needed. The person's experience/knowledge providing the good and/or service matches the good/service provided.

**Frequency of Verification:**

Annually or at the time of purchase.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:**

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

11 Other Health and Therapeutic Services

11080 occupational therapy

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

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

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


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

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

**Service Definition (Scope):**

Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term “occupation” as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performances. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning. Provision of this service will prevent institutional placement. Therapist may also provide consultation and training to staff or caregivers (such as client’s family and /or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Occupational Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

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

Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed in 15-minute units of service. Occupational therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan. Group therapy is not allowed.

**Documentation**

Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Qualified Individual Employed by a Self-Directing Participant or Family
Agency	Occupational Therapist employed or contracted by a certified agency.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational Therapy****Provider Category:**

Individual ▾

**Provider Type:**

Qualified Individual Employed by a Self-Directing Participant or Family

**Provider Qualifications****License (specify):**

Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5

**Certificate (specify):**

Certified waiver providers are certified under Al. Administrative Code Chapters 580-3-23, 580-5-30, 580-5-31 and 580-5-32

**Other Standard (specify):**

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

DMH/DDD Certification Surveyors. The FMSA (Financial Management Service Agency) will verify the qualifications prior to enrolling the occupational therapist. This verification need only be made initially. If the occupational therapist is also employed by an agency, and thus certified by the Operating Agency, the FMSA may accept the Operating Agency's verification of qualifications.

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational Therapy****Provider Category:**

Agency ▾

**Provider Type:**

Occupational Therapist employed or contracted by a certified agency.

**Provider Qualifications****License (specify):**

Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5

**Certificate (specify):**

Certified waiver providers are certified under Al. Administrative Code Chapters 580 Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard (specify):**

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

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Personal Emergency Response System

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PEF

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. This service may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate.

The use of these technologies requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The person centered plan should identify options available to meet the need of the individual in terms of preference while also ensuring health, safety, and welfare. Personal risk factors should be discussed, information regarding data collection should be discussed, customized list of individuals/providers to be notified of alerts should be customized, who will be

allowed access to data (service provider/staff), and choice should be afforded between providers both equipment and monitoring. The person centered plan should also include the purpose of the PERS, back-up system for PERS in times of electronic outages or failure, training of caregiver (paid and unpaid), provider/caregiver response time for different events, safeguards for protection of the person's privacy related to remote support and data collection. If remote support includes video (in person's bedroom), informed consent must be addressed (and documented) and privacy concerns should be addressed.

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

Emergency Response System installation and testing is approximated to cost \$500.00; Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than \$83.00/month; Emergency Response system purchase is approximated to cost \$1,500.00. The maximum cost for all PERS per year is \$3000.00

This service will not be authorized for person's receiving residential habilitation. PERS will not replace supervision and monitoring of activities of daily living which are provided to meet requirements of another service (i.e. personal care; day habilitation).

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Service Provider Agency and authorized PERS vendor
Agency	Self Directed authorized PERS vendor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response System**

**Provider Category:**

Agency ▼

**Provider Type:**

Service Provider Agency and authorized PERS vendor

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.

## PERS Minimum Requirements:

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

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

DMH

**Frequency of Verification:**

At time of purchase.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Emergency Response System****Provider Category:**Agency **Provider Type:**

Self Directed authorized PERS vendor

**Provider Qualifications****License (specify):**



**Certificate (specify):**



**Other Standard (specify):**

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.

## PERS Minimum Requirements:

- 1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response.
- 2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person centered plan or PERS parameters.
- 3) A call tree that reflects the person's needs and preferences.
- 4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and

Accountability Act (HIPAA) and all other data privacy laws and requirements.

5) Address the documented risk factors and preferences of the person.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMSA

**Frequency of Verification:**

At time of purchase.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Physical Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

11 Other Health and Therapeutic Services	11090 physical therapy
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**Category 2:**

**Sub-Category 2:**

	▼
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**Category 3:**

**Sub-Category 3:**

	▼
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**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Physical therapy is physician prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

- preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and

- prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Therapist may also provide consultation and training to staff or caregivers (such as client’s family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Physical Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

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

Documentation in the case record must justify the need for service. Services must be listed on the care plan and be provided and billed in 15-minute units of service. Physical therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan. Group therapy is not allowed.

**Documentation**

Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Physical Therapist employed or contracted by a certified agency.
Individual	Qualified Individual Employed by a Self-Directing Participant or Family

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Physical Therapy**

**Provider Category:**

Agency

**Provider Type:**

Physical Therapist employed or contracted by a certified agency.

**Provider Qualifications**

**License** (*specify*):

Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212

**Certificate** (*specify*):

Certified Waiver Providers are certified under Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Physical Therapy**

**Provider Category:**

Individual ▾

**Provider Type:**

Qualified Individual Employed by a Self-Directing Participant or Family

**Provider Qualifications**

**License (specify):**

Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212

**Certificate (specify):**

Certified Waiver Providers are certified under Al. Administrative Code Chapters 580-3-23, 580-5-30, 580-5-31 and 580-5-32

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors. The FMSA (Financial Management Service Agency) will verify the qualifications prior to enrolling the physical therapist. This verification need only be made initially. If the physical therapist is also employed by an agency, and thus certified by the Operating Agency, the FMSA may accept the Operating Agency's verification of qualifications.

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Positive Behavior Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

10 Other Mental Health and Behavioral Services

10040 behavior support

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

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

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


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

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

**Service Definition (Scope):**

Positive Behavior Support (PBS) is a set of researched-based strategies that combine behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a person's environment. The strategies take into consideration all aspects of the person's life and are intended to enhance positive social interactions across work, academic, recreational, and community settings while reducing actions that are not safe or that lead to social isolation, loneliness or fearfulness. PBS provides framework for approaches that emphasize understanding the person, strengthening environment that build on individual strengths and interests, and decreasing interventions that focus on controlling problematic behavior in order to fit the person's environment. Some of the billable tasks include, but are not limited to: conducting functional behavior assessments, behavior support plan (BSP) development, training to implement the BSP, data entry/analysis/graphing, monitoring effectiveness of BSP, writing progress notes/reports, etc. BSP may include consultation provided to families, other caretakers, and habilitation services providers. BSP shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and its continued use must be reviewed every thirty days with reports due quarterly.

Positive Behavior Support (PBS) waiver service is comprised of two general categories of service tasks. These are (1) development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS tasks.

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

The maximum units per year of both professional and technician level units in combination cannot exceed 1200 and the maximum units of any combination of professional level one (1) or two (2) cannot exceed 800. Maximum units of Technician level service are the balance between billed professional level one (1) and two (2) units and the combined maximum per year. Professional level providers may provide more than the 800 unit limit, but these additional units will be paid at the Technician level up to the 1200 max on total units. Providers of service must document which tasks are provided by date performed in addition to their clinical notes. There will be no accommodation for exceeding the overall cap of 1200 units for all three levels. The following do not qualify for billing under this waiver service: 1) individual or group therapy, 2) group counseling, 3) behavioral procedures not listed in a formal BSP or that do not comply with the current Behavioral Services Procedural Guidelines and Community Certification Standards, 4) non-traditional therapies, such as music therapy, massage therapy, etc., 5)

supervision.

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

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

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

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Self Directed Board Certified Behavior Analyst or Assistant
Agency	Individual employed or contracted by a certified agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Positive Behavior Support**

**Provider Category:**

Individual ▾

**Provider Type:**

Self Directed Board Certified Behavior Analyst or Assistant

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

Board Certified Behavior Analyst or Assistant

**Other Standard** (specify):

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board.

Behavior Analysis Certification Board  
 3323 Thomasville Rd. Suite B  
 Tallahassee, FL 32308  
 Phone (850) 386-4444; FAX (850) 386-2404; Web www.BACB.com

Level 2: Providers must have either a Doctoral or Master's level degree in the area of Behavior Analysis, Psychology, Special Education or a related field and three years' experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision.

Level 3: Providers must be either a QIDP (per the standard at 43 CFR 483.430) or be a Board Certified Assistant Behavior Analyst (BCABA). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All PBS service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated. The orientation will be provided by DDD via Department of Mental Health's e-learning software. The DMH will maintain a registry of trained BPS providers and record of their orientation. The provider will maintain a record of who is supervising the Level 3 provider and will make available upon request/audit.

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DMH/DDD Director of Psychological and Behavioral Services and FMSA.

**Frequency of Verification:**

Upon enrollment.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Positive Behavior Support**

**Provider Category:**

Agency 

**Provider Type:**

Individual employed or contracted by a certified agency.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Board Certified Behavior Analyst or Assistant

**Other Standard (specify):**

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board.

Behavior Analysis Certification Board  
3323 Thomasville Rd. Suite B  
Tallahassee, FL 32308  
Phone (850) 386-4444; FAX (850) 386-2404; Web www.BACB.com

Level 2: Providers must have either a Doctoral or Master's level degree in the area of Behavior Analysis, Psychology, Special Education or a related field and three years experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision.

Level 3: Providers must be either a QIDP (per the standard at 43 CFR 483.430) or be a Board Certified Assistant Behavior Analyst (BCABA). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All PBS service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated. The orientation will be provided by DDD via Department of Mental Health's e-learning software. The DMH will maintain a registry of trained BPS providers and record of their orientation. The provider will maintain a record of

who is supervising the Level 3 provider and will make available upon request/audit.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Residential Habilitation Other Living Arrangement (OLA)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Residential Habilitation (Other Living Arrangement)

Residential habilitation services provide care, supervision, and skills training in activities of daily living, home management and community integration. In this waiver, residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities. A unit of service is 15 minutes. The place of service will primarily be the person's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

Residential habilitation goals must relate to identified, planned goals. Training and supervision of staff by a QDDP shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements are specified below; these must be met prior to the staff beginning work. Additional training to specifically address and further the goals in the individual's plan may occur on the job. Consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

The service includes the following:

- Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (i.e. moving a chair, substituting velcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.
- Habilitation supplies and equipment; and
- Transportation costs to transport individuals to day programs, social events or community activities when public transportation and/or transportation covered under the Medicaid state plan are not available will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

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

In this waiver, residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities.

The service excludes the following:

- Services, directly or indirectly, provided by a member of the individual's immediate family;
- Routine care and supervision which would be expected to be provided by a family;
- Activities or supervision for which a payment is made by a source other than Medicaid; and
- Room and board costs.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Waiver Hourly Services Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Residential Habilitation Other Living Arrangement (OLA)**

**Provider Category:**

Agency ▼

**Provider Type:**

Certified Waiver Hourly Services Provider

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

Al. Code Administrative Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

Documentation:

Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumer's plan of care.

**Residential Habilitation Provider Qualifications**

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Residential Habilitation Other Living Arrangement services. Standards are in Alabama Administrative Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide Residential Habilitation Services under this waiver does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's home (including family home). Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Certification surveys will follow the standards for Hourly Service Providers, and may include visits to the homes of individuals being served.

When the application, supporting data, and site visit, if applicable, prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Residential Habilitation Other Living Arrangement services shall have a written mission statement for dissemination to prospective clients and their families. This mission statement shall address:

Program philosophy and purpose;  
Geographical area served;  
Range of services provided; and  
Population served, including criteria for service eligibility, program admission and program discharge.

Program staff ratios and schedules shall be maintained to meet the needs of the consumer. An emergency, on-call staff person shall be available. Staff scheduling and work place assignments shall be so arranged as to provide continuous on-site response capability in the event of client needs. The staffing pattern shall be appropriate to the type and scope of programmed services. Staff shall meet qualifications in the approved job descriptions.

Residential Habilitation services will be delivered/supervised by a Qualified Developmental Disabilities Professional in coordination with the individual's plan of care.

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

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Skilled Nursing

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing ▼

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Services listed in the service plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. There is no restriction on the place of service.

This service may also, when provided to a participant or family which is self-directing personal care services, include training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker. This training and supervising component of nursing is only available to people who receive personal care at home, either agency-based or self directed. It is not available to agencies providing residential and day programs, because payment for the nurse supervision is already included in the rate paid for those services.

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

When Nursing is provided to self-directing participants and families, it is intended to focus on training and supervision of the personal care worker and is not intended as a private duty nursing service.

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

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

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

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Registered or Licensed Practical Nurse
Individual	Registered or Licensed Nurse Employed by a Self Directing Participant or Family

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Skilled Nursing**

**Provider Category:**

Agency ▼

**Provider Type:**

Registered or Licensed Practical Nurse

**Provider Qualifications**

**License** (*specify*):

Nurses are licensed under the Code of Alabama; 1975 Sec.34-21

**Certificate** (*specify*):

Nurses typically are employed by certified waiver providers, certified under Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard** (*specify*):

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in consumer's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Alabama Board of Nursing verifies nursing licenses. DMH/DDD Certification Surveyors verify waiver provider certification.

**Frequency of Verification:**

Nursing licenses are renewed annually. Waiver provider certification occurs prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Skilled Nursing**

**Provider Category:**

Individual ▼

**Provider Type:**

Registered or Licensed Nurse Employed by a Self Directing Participant or Family

**Provider Qualifications****License** (*specify*):

Al. Administrative Code Chapters 580-3-23 580-5-33.

**Certificate** (*specify*):
**Other Standard** (*specify*):

The FMSA (Financial Management Services Agency) will hold the provider enrollment by permission of the Alabama Medicaid Agency.

Note that a nurse, either an RN or an LPN, may work for an agency and also work for an individual or family, so long as there is no duplication of payment or conflict of interest. Either issue would involve the nurse working for an agency which also provides direct services to the participant who is self-directing his or her personal care. Because both the agency's service and the self-directed service will need to be prior authorized (all waiver services are prior authorized from the plan of care), this potential conflict / duplication would be apparent to the Operating Agency, which will ensure it does not arise.

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in participant's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note.

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

The Alabama Board of Nursing verifies nursing licenses. The FMSA (Financial Management Services Agency) will verify the nurse is Licensed.

**Frequency of Verification:**

Licenses for Nursing are renewed annually. The FMSA verification will be annual as well.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**


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

**Service Title:**

Specialized Medical Equipment

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14031 equipment and technology

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

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Specialized medical equipment includes devices, controls, or appliances specified in the service plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. All items shall meet applicable standards of manufacture, design and installation.

Providers of this service must maintain documentation of items purchased for each individual.

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

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. Payment is for the cost of the item provided. There is a \$5,000 per year, per individual maximum cost.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Self Directed Home Medical Equipment Agency
Agency	Home Medical Equipment and Services Providers

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment****Provider Category:**

**Provider Type:**

Self Directed Home Medical Equipment Agency

**Provider Qualifications**

**License (specify):**

Licensure is by the Alabama Board of Home Medical Equipment Services Providers.

**Certificate (specify):**

**Other Standard (specify):**

Providers of this service must meet the same standards required for the providers under the Alabama State Plan.

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

FMSA

**Frequency of Verification:**

Upon purchase.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specialized Medical Equipment**

**Provider Category:**

Agency 

**Provider Type:**

Home Medical Equipment and Services Providers

**Provider Qualifications****License (specify):**

Alabama Code Chapter 34-14C-1 through 8

**Certificate (specify):**

**Other Standard (specify):**

Providers of this service must meet the same standards required for the providers under the Alabama State Plan.

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

Licensure is by the Alabama Board of Home Medical Equipment Services Providers

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service 

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

**Service Title:**

Specialized Medical Supplies

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

14 Equipment, Technology, and Modifications	14032 supplies
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**Category 2:**

**Sub-Category 2:**

	▼
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**Category 3:**

**Sub-Category 3:**

	▼
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**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Specialized medical supplies are those which are specified in the plan of care and are necessary to maintain the individual's health, safety and welfare, prevent further deterioration of a condition, or increase an individual's ability to perform activities of daily living. All items shall meet applicable standards of manufacture and design.

Providers of this service must maintain documentation of items purchased for each individual.

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

Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the recipient. Costs for medical supplies are limited to \$1800 per year, per individual.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Waiver Provider
Agency	Self Directed Durable Medical Supplies Vendor

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Specialized Medical Supplies**

**Provider Category:**Agency **Provider Type:**

Certified Waiver Provider

**Provider Qualifications****License (specify):****Certificate (specify):**

Waiver providers are certified under Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B.

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Supplies****Provider Category:**Agency **Provider Type:**

Self Directed Durable Medical Supplies Vendor

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Authorized Medical Supplies Vendor.

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

FMSA

**Frequency of Verification:**

Upon enrollment.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Speech and Language Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

11 Other Health and Therapeutic Services

11100 speech, hearing, and language therapy

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). These services may include:

Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' habilitation programs; and

Treatment services as an extension of the evaluation process that include:

- consulting with others working with the individual for speech education and improvement,
- designing specialized programs for developing an individual's communication skills comprehension and expression.

Provision of this service in the community is an alternative to an institutional level of care.

Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Speech Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

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

Services must be listed on the care plan and prescribed by a physician. The need for service must be documented in the case record. Services shall be provided and billed as an encounter unit of service. Speech/language therapy

under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan. Group therapy will not be reimbursed.

#### Documentation

Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

#### Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Individual Employed by a Self-Directing Participant or Family
Agency	Speech Therapist employed or contracted by a certified agency

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Speech and Language Therapy

#### Provider Category:

Individual ▾

#### Provider Type:

Qualified Individual Employed by a Self-Directing Participant or Family

#### Provider Qualifications

##### License *(specify):*

Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7

##### Certificate *(specify):*

Certified waiver providers are certified under Al. Administrative Code Chapters 580-3-23, 580-5-30, 580-5-31 and 580-5-32

##### Other Standard *(specify):*

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DMH/DDD Certification Surveyors. The FMSA (Financial Management Service Agency) will verify the qualifications prior to enrolling the speech therapist. This verification need only be made initially. If the speech therapist is also employed by an agency, and thus certified by the Operating Agency, the FMSA may accept the Operating Agency's verification of qualifications.

##### Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Speech and Language Therapy**

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**Provider Category:**

Agency ▾

**Provider Type:**

Speech Therapist employed or contracted by a certified agency

**Provider Qualifications****License (specify):**

Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7

**Certificate (specify):**

Certified waiver providers are certified under Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard (specify):**

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

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Supported Employment Emergency Transportation

**HCBS Taxonomy:****Category 1:**

15 Non-Medical Transportation

**Sub-Category 1:**

15010 non-medical transportation ▾

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Supported Employment Emergency Transportation is the provision of service to permit waiver participants access to and from their place of employment in the event that the support team is unable to facilitate transportation arrangements quickly or there is a risk of the participant missing a day of scheduled work. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. In addition, this does not preclude other arrangements such as transportation by family or friend. It is the expectation that, as part of the person centered planning process and employment outcomes, that long term transportation to and from the worksite will be facilitated and arranged.

Payments for this service will be reimbursed based on documentation (i.e. vendor receipt or travel log) of service or by mile up to the maximum allowable in a year. The unit of service is an item or mile.

Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. Taxicab). Commercial transportation agency - Must have a business license. All drivers must have a valid driver's license of appropriate type (e.g. commercial) for transport in Alabama. A list of transportation resources by county is posted on the Department of Mental Health's website.

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

When this service is provided it is intended to be temporary until long term transportation arrangements have been solidified. The unit of service is an item or mile, to be reimbursed based on adequate documentation. Documentation for Medicaid reimbursement includes actual receipts from public or private transportation providers or mileage logs and should also include progress toward obtaining long term transportation as part of measuring the employment outcomes.

Payment made for mileage includes the provider's cost of an insurance waiver to cover any harm that might befall the participant as a result of being transported. The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a participant. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Supported Employment Specialized Transportation is not intended to replace generic transportation or to be used merely for convenience. A maximum amount of \$1000 per fiscal year is allowable.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Day Habilitation Program
Agency	Public Mass Transit
Agency	Certified Waiver Hourly Services Provider

Agency	Taxi or Common Carrier
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## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment Emergency Transportation**

**Provider Category:**

Agency ▼

**Provider Type:**

Certified Day Habilitation Program

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Other Standard (specify):**

If providing transportation, must have valid driver's license and insurance as required by State Law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment Emergency Transportation**

**Provider Category:**

Agency ▼

**Provider Type:**

Public Mass Transit

**Provider Qualifications**

**License (specify):**

CDL License

**Certificate (specify):**

**Other Standard (specify):**

Those who want to drive school buses, church buses, shuttles or charter buses carrying 16 or more passengers, must get a Commercial Driver's License Endorsement Class C on their regular driver's license.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AL Department of Public Safety: Commercial Driver's License Office.

**Frequency of Verification:**

Every four years.

## Appendix C: Participant Services

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

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**Service Type:** Other Service

**Service Name:** Supported Employment Emergency Transportation

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**Provider Category:**

Agency 

**Provider Type:**

Certified Waiver Hourly Services Provider

**Provider Qualifications**

**License** (*specify*):

Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B

**Certificate** (*specify*):



**Other Standard** (*specify*):

Must have valid driver's license and insurance as required by State Law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DMH/DDD Certification Surveyors

**Frequency of Verification:**

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

## Appendix C: Participant Services

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

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**Service Type:** Other Service

**Service Name:** Supported Employment Emergency Transportation

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**Provider Category:**

Agency 

**Provider Type:**

Taxi or Common Carrier

**Provider Qualifications**

**License** (*specify*):

Valid driver's license (called a Class D).

**Certificate** (*specify*):



**Other Standard** (*specify*):

Taxi drivers and chauffeurs in Alabama are required only to have a regular current, valid driver's license (called a Class D) and a business license, to operate.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AL Department of Public Safety: Local Driver's Licensing Office or Probate Court.

**Frequency of Verification:**

Every four years.

## Appendix C: Participant Services

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

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to

waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.  
*Check each that applies:*
  - As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - As an administrative activity.** *Complete item C-1-c.*

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

Local agencies established under Act 310 of the Alabama Statutes and Regional Offices of the Division of Developmental Disabilities.

## Appendix C: Participant Services

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

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

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

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

Executive Officers and owners of provider agencies must obtain both a statewide and a national criminal background clearance. This is a condition for initial certification. This is the responsibility of the Life Safety Division of the Operating Agency. Direct care staff must have a background check from local law enforcement, and a statewide or national check as indicated by the staff member's previous residences and work history. This is checked as a component of the certification survey.

A completed application for certification must be sent by the provider/applicant to DMH Facilities Certification Office (Life Safety) at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

DMH may accept a certification/license/ accreditation issued by other generally accepted recognized state or national organizations in lieu of an additional review through the DMH certification process. However, DMH reserves the right to apply DMH certification standards to areas it determines are not adequately addressed in other state or national standards. Further, the DMH reserves the right to conduct reviews, including onsite visits if appropriate, of programs that are certified/licensed/accredited by other entities where there is evidence of significant deficiencies.

The DMH Facilities Certification Office submits the application to the respective DMH Division(s) for approval according to the type(s) of services proposed by the provider.

The applicable DMH Division(s) review/approve the application and returns a copy of the approval to the DMH Facilities Certification Office. An initial Life Safety and Programmatic review is conducted, if applicable, by

designated DMH representatives. Applications remain valid for up to six (6) months after receipt by DMH if the service has not been initiated by the provider or approved by DMH.

For new applicants/providers, the DMH will conduct criminal background checks on the primary operator and/or subcontractor of the program as defined in the Alabama Administrative Code, Section 580 3 23 .06(1)(a) and Section 580 3 23 .06(1)(b).

Once the provider completes the application process, and based upon its representations of compliance with applicable DMH standards, the program is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.

Author: DMH Office of Certification

Authority: Code of Ala. 1975, §22 50 11.

All employees/volunteers/agents of the provider have reference and background checks prior to employment. Background checks cover the employer's local vicinity and state. National checks are completed if applicable. Resources to assist in this process include the Department of Public Safety, the Department of Public Health's Abuse Registry, as well as DMH's Term-Trac database. Drug testing is included as part of the pre-employment screening process for employees whose job duties involve the care, safety and wellbeing of people and on reasonable suspicion (for-cause) of any employee of the organization. The organization does not hire people who have been convicted of felony crimes.

The Medicaid Re-enrollment process that is on-going assumes the responsibility of ensuring Executive Directors and owners are not listed in any federal exclusion lists.

For participants who are self-directing services, all staff employed by the participant will have a criminal background check completed by the FMSA (Financial Management Service Agency) via internet. Nurses already are licensed by the Alabama Board of Nursing, which includes background screening. The Operating Agency reviews this information on a quarterly basis.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

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

The Operating Agency holds semi-annual orientations for individuals and agencies interested in enrolling in any of the programs and services offered by the Alabama Department of Mental Health, including the waiver programs. This orientation is advertised on the Department's website as a necessary step in becoming enrolled, and details and contact information is included in the advertisement, copied and reprinted below.

The Alabama Department of Mental Health has oversight for a broad network of care, treatment, programs, and services that specifically enable persons with mental illnesses, developmental disabilities, or substance abuse disorders to reside in communities. Individuals and organizations that provide services or are interested in providing such services in your communities must meet certain requirements and must be certified by the Alabama Department of Mental Health.

To begin the process, prospective providers must complete two training courses designed to provide essential information about the certification process, including information on life safety and physical facility standards, nurse delegation, criminal background checks, programmatic requirements, and certification administration, as well as instruction on how to complete the certification application.

\* The first course is an online course; this course provides information that will give individuals a general idea of the certification requirements. It includes a test at the end, and a certificate may be generated as verification of completion. Prospective providers should click on the ADMH Education Website link at the bottom of this page to complete the online course. (Also, please click on the instructions link below, to print instructions for accessing and completing the online course.)

\* On successful completion of the online course, prospective providers should register to attend the one-day mandatory live orientation program called "Prospective Community Provider Orientation". This live orientation is presented in an open forum format that provides instruction as well as an opportunity for prospective providers to have their questions answered. Throughout the day, knowledgeable ADMH staff will be available to serve as resources for beginning the certification process. To register for the live orientation program, download the registration form by clicking on link below. You must complete the registration form and submit it as instructed on the form, along with the online course completion certificate and the non-refundable \$75 registration fee.

A completed application for certification must be sent by the provider/applicant to DMH Facilities Certification Office (Life Safety) at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

Once the provider completes the application process, and based upon its representations of compliance with applicable DMH standards, the program is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.

Author: DMH Office of Certification

Authority: Code of Ala. 1975, §22 50 11.

If you have questions about the class registration process, please contact us by email:  
StaffDevelopment.DMH@mh.alabama.gov

Links:

\* To access the online course, click here:

ADMH Continuing Education Website for Mental Health Providers and Professionals

\* Instructions for Accessing and Completing the Online Course

\* Prospective Community Provider Orientation Registration Form

\* To Confirm Receipt of Your Registration

\* To Obtain Directions and Parking Information

\* Map to Capitol Complex

Be sure to visit other areas of the Alabama Department of Mental Health website, including Certification Administration, Life Safety and Technical Services, Nurse Delegation Program, and the Bureau of Special

Investigations, which are all areas involved in the certification process. There are many other resources available through each of the department's service divisions - Developmental Disabilities (formerly Intellectual Disabilities or Mental Retardation) and the division of Mental Illness and Substance Abuse. You may also find an abundance of general information on the Internet under the small business administration websites that will give you insight on starting a business in Alabama.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### a. Methods for Discovery: Qualified Providers

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**1. Number and percent of newly enrolled providers that meet state standards/requirements. Percent equals newly enrolled providers that meet state standards/requirements divided by the total number newly enrolled providers.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Certification Surveys include Record Reviews Onsite and Onsite Observation, Interviews and Monitoring.**

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

		<input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Providers which score above 89% are given a two-year certificate and certified less than annually.	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**2. Number and percent of currently enrolled providers that meet state standards/requirements. Percent equals the number of currently enrolled providers that meet state standards/requirements divided by the total number currently enrolled providers.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Certification Surveys include both Record Reviews onsite and Onsite Observaton,**

**Interviews and Monitoring.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Providers which score above 89% are given a two-year certificate and certified less than annually.	

**Data Aggregation and Analysis:**

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

**Other**  
Specify:

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

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

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

**Performance Measure:**

**1. Number and percent of new self-directed employees/staff that meet state requirements. Percent equals number of new self directed employees that meet state requirements divided by the number of new self directed employees/staff.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**FMSA employee enrollment packet**

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

	Specify:	
	<input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

**1. Number and percent of providers which meet training requirements. Percent equals the number of providers certified during a period which met training requirements divided by total number of providers certified during that period.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Certification Surveys include Record Reviews Onsite and Onsite Observation, Interviews and Monitoring**

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

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Providers which score above 89% are given a two-year certificate and certified less than annually	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**2. Number and percent of non-licensed/non-certified providers that meet training**

requirements. Percent equals the number of enrolled non-licensed/non-certified providers that meet training requirements divided by the total number of sampled self-directed employees.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**FMSA: Training verification**

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

Data Aggregation and Analysis:

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the 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 and either annually or bi-annually, 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.

With regard to performance measure a.i.b. above (non certified providers), this measure only applies to staff employed by consumers / families under the self direction described in Appendix E. If, during the ongoing review of records supplied by the FMSA non-qualified staff are found, payments to those staff will be recouped.

- ii. **Remediation Data Aggregation**

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

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

<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

- No**  
 **Yes**

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

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.  
 **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*
- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*
- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

ID Waiver participants live and receive waiver services in a variety of different community settings. Roughly 37% of waiver participants (including both ID Waiver and Living at Home Waiver) reside in their own home or with relatives and/or caregivers. About 78% of waiver participants are receiving Day Habilitation. Day Habilitation is provided within the community. Day Habilitation services and settings can include: volunteer work in the community, community experience activities (libraries, parks, special community events), and extracurricular activities such as horseback riding, and educational activities (learning a trade). Employment supports are provided on the worksite (job coach, personal care on worksite) as well.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

The state Medicaid Agency communicated with the Operating Agency regarding the provider self-assessment tool used for each waiver program site to determine whether the waiver settings meet the HCB settings requirements. The tool was developed by the Operating Agency who developed an assessment of indicator for each bullet point in the regulation and added probing questions to assist if needed. A summary report was provided to AL Medicaid Agency that included remediation plans of settings that did not meet the HCB settings requirements. The Medicaid Agency will be doing on-going

monitoring to ensure that all settings will continue to meet the HCB settings requirements. On-going monitoring will be done through home visits to clients homes and the customer satisfaction survey will be revised to include questions that address the HCB settings requirements.

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Individual Service Plan

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

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

A four-year college degree in a human service-related field and completion of a specified course of instruction approved by the Alabama Medicaid Agency and the Department of Mental Health.

- Social Worker**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

The individual's team, composed of the individual, family/guardian & friends, as appropriate, case manager, QIDP or Community Specialist, and all other persons providing services and support to the individual is responsible for development of the person centered plan. It is important that people are present that know the individual very well. The QIDP or Community Specialist must satisfy the qualifications for a Qualified Intellectual Disabilities Professional set forth in the Code of Federal Regulations.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Please note that the state is in the process of ensuring that all case management is free from conflict of interest, with the only exception being for rural areas that meet the CMS guidelines for exemption.

DMH/DDD has one distinct action items for ensuring case management is free from conflict of interest and remains free from conflict of interest. This action item is to develop a geospatial assessment (map) of all provider sites. The purpose of the mapping is to identify areas in the state where there are clusters of service providers

and where there are limited to no service providers. The mapping tool will overlay provider site location data with other community resource data (i.e. churches, colleges, etc.) in order to visually pinpoint areas of limited to no service availability. The mapping tool is intended to be interactive in order to meet the needs of various users. The GEO Mapping Requirement Specifications were submitted to internal state GEOSPACTIAL personnel on March 13, 2015. The project should be completed by the end of the fiscal year September 30th, 2015. At this time the state will submit an amendment with required updates based on the assessment tool which will include firewalls ensuring case management is free from conflict of interest, as well as details as to why any rural area provider determined to meet the CMS guidelines for exemption are the only willing and qualified provider.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Division has long been an advocate for an individualized planning process and in its commitment spent a considerable amount of time developing and training a uniquely blended approach that includes Personal Profile Frames and PATH (Planning Alternative Tomorrows with Hope). The Personal PATH is a positive action plan for the focus person (participant), created from the Personal Profile Frames, by working with the focus person, family, friends, and other associates. The focus person should participate as much as possible in the development of the PATH. It is also very important that other people be present that know the person very well and have access to records and pertinent information. The PATH crosses all areas of life. Additionally when goals are established a support team needs to be in place. The support team is not limited to paid staff, service providers, agencies, programs, schools, locations etc. The support team should be balanced with neighbors, relatives, friends, and others interested in the individual and his/her success.

Once it is determined what services will be needed to support the person, information is provided to the individual and/or family by the 310/case management entity, regarding providers in their respective area, that offer the services and supports they are requesting. Direct service providers and the Regional Community Services Office also make information available. Visits are arranged, upon request, to the various service provider's sites to give individuals an opportunity to make an informed decision about their services and supports.

The individual's team, composed of the individual, family/guardian & friends, as appropriate, case manager, QIDP or Community Specialist, and all other persons providing services and support to the individual is responsible for development of the person centered plan. It is important that people are present that know the individual very well.

The DDD is in the process of developing standard case management protocol that will better serve waiver participants especially as it relates to the planning process. The case manager continuously follows up/monitors the services and facilitates adjustments so that desired outcomes are achieved. When there is no evidence that the desired outcomes are being achieved, it is the case manager who must initiate the necessary steps to assist the waiver participant in making needed change and to ensure that modification of the Person Centered Plan is appropriately addressed.

Case managers maintain a comprehensive, objective viewpoint broad enough to ensure that services and supports are exceeding the expectations of the waiver participant. It is from this objective/conflict free viewpoint that the case manager advocates on behalf of the waiver participant.

One of the more critical pieces of information sharing is the actual services available through the waiver, their definitions, their limitations, and whether a particular service would fit that individual's need based on the Person Centered Planning process and the Person Outcomes Measures. At this time we are looking at the case manager as the resource for this information. As part of the protocol, a process for describing the entire list of services will be adopted.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Overview: There is a global service plan (Person Centered Plan) that is developed with the individuals, family/guardian and friends as appropriate and other persons that provide services and supports to the individual, as appropriate in the planning process, i.e. PT, OT. The Case Manager is the "keeper" of the plan, but usually is not the sole writer. The team which makes the plan provides information for the profile descriptions, and the designated recorder for the planning meeting will type those up to be included in the plan. QIDPs with the direct service provider each write elements of the plan, and the Case Manager incorporates those. The Case Manager then briefly summarizes all areas of needed services and supports on the Medicaid Waiver Plan of Care along with services and supports that the individual is currently receiving regardless of the funding source.

- a. Who Develops the Plan, who participates in the process, and the timing of the plan?

The individual's team, composed of the individual, family/guardian & friends, as appropriate, case manager, QIDP or Community Specialist, and all other persons providing services and supports to the individual is responsible for development of the individual's service plan. Invitations are extended to, and efforts are made to include, all persons that the individual requests to be invited to his/her meeting. Other specialty areas may not be present at the meeting but may provide written input such as a physician's report or PT/OT evaluations. The case manager is the official caretaker of the person centered plan (PCP), responsible for coordinating the efforts of the team and making sure the plan gets written and implemented. Initial plans are fully developed in advance of waiver enrollment and submitted as part of the enrollment packet. Subsequent plans are then developed, at a minimum, prior to annual re-determinations for the waiver. Team meetings are called during the year to address changes in the participant's situation or requests for additional or different services or providers.

- b. The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status?

The case manager conducts a history and profile of the individual and family prior to the team meeting. In addition, the planning meeting itself produces an extensive profile to support the planning process. The profile components identify wants and needs, the resources and supports currently available to meet the wants and needs, and the resources and supports needed to meet each want and need. The wants and needs addressed in the profile include but are not limited to: Housing, Safety, Supervision, Communication, Mobility, Family and Friends, Recreation and Leisure, Health and Medical Care, Transportation, Education and Training, Employment or Day Activities, Daily Living (e.g. food, clothing, activities of daily living), Finances and Money Management, and Emotional or Behavioral Needs. In addition, profiles cover discussions, for instance, of what and who is important to the individual, what are the individual's daily routines and what choices does he or she get to make, what works and doesn't work for the individual, and what does the team need to know and do to support the individual. Other profiles and sub assessments are available as needed for special needs in health management employment, communication and behavioral support. For example, the Division has been utilizing the Health Risk Screening Tool to assist in identifying risk factors for a sub-group waiver participants in order to identify needs and access recommendations for services.

The Division has been actively working with CQL (The Council on Quality and Leadership) for many years in the development and implementation of person centered planning strategies, as well as, new certification standards. Through this consultation the Division implemented a certification process known as the Basic Assurances System which utilizes the Personal Outcome Measures(c) interview process. The Personal Outcome Measures(c) process supports the person-centered planning process and allows the Division to self-assess areas of both strength and weakness for systemic quality improvement.

Personal Outcome Measures(c) are listed below:  
 People are connected to natural support networks  
 People have intimate relationships  
 People are safe

People have the best possible health  
 People exercise rights  
 People are treated fairly  
 People are free from abuse and neglect  
 People experience continuity and security  
 People decide when to share personal information  
 People choose where and with whom they live  
 People choose where they work  
 People use their environments  
 People live in integrated environments  
 People interact with other members of the community  
 People perform different social roles  
 People choose services  
 People choose personal goals  
 People realize personal goals  
 People participate in the life of the community  
 People have friends  
 People are respected

From the information gathered before and during the team meeting, a person centered plan is developed, which is essentially an action plan. The preferred action plan is the PATH, but other forms, including to do lists which include who is responsible for each action and when it is to be accomplished, are acceptable for now. The Medicaid Plan of Care is basically a recap of the action plan.

c. How the participant is informed of the services that are available under the waiver.

Once there is a determination of needs from the person centered planning process, information is provided to the individual and/or family by the case management agency (case manager or an intake specialist), regarding providers in their respective area, that offer the services and supports they are requesting. Direct service providers and the Regional Community Services Office also make information available. Visits are arranged, upon request, to the various service provider's sites to give individuals an opportunity to make an informed decision about their services and supports.

d. How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences?

The person centered plan is developed with the individual, family/guardian and friends as appropriate and other persons that provide services and supports to the individual as appropriate. The plan identifies individual strengths as well as areas where the individual requires supports. The profile information that is gathered before and during the team meeting is very thorough and identifies all areas of needed services and supports, and clearly delineates the individual participant's preferences. Additionally, the Personal Outcome Measures(c) specifically speaks to choosing and realizing personal goals, people are safe and have the best possible health, and people get to choose (i.e. where they work, where they live, and who they live with).

Each person's medical status and needs are reviewed annually within ninety (90) days prior to or at the same time as the annual person-centered plan meeting. This is evidenced by a report from a physical examination by a licensed physician or certified registered nurse practitioner conducted within the last year. People are assisted in obtaining preventive and routine health services including physical examinations, immunizations and screenings that are consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the person centered plan, based on the person's current health status and age, are implemented and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age specific screening tests. Each person's person-centered plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT and psychiatric services. As part of the person centered plan, health care plans and supports are modified in a timely manner based upon acute health care changes.

e. How waiver and other services are coordinated?

The service plans address all supports and services an individual is to receive, including both services provided through the waiver and services provided through other means. For each need, the plan must describe the service or support which will meet that need, and who will provide it. Case managers are responsible for coordinating services

provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

The PATH action plan will outline what everyone is to do to implement the plan, and the case manager's responsibilities will include monitoring the plan's implementation. The direct service provider has the first responsibility for monitoring its own services to assure the implementation of the person centered plan and the participant's health and welfare. External monitoring, however, is also in place. The case manager, as stated above, monitors/reviews services, and does so on a minimum quarterly basis. In addition, The Regional DMH Office provides a 6 month minimum visit/review to each service site and a semi-annual random review of case management records. Additionally, The DMH Programmatic Certification offices and the Basic Assurances System has monitoring of the person centered plan imbedded throughout the tool. If a provider fails to comply that specific indicator will be marked accordingly which impacts the assurance score and ultimately the overall certification score. Other monitoring and technical assistance reviews are completed by DMH Advocacy office and DMH Quality Enhancement office. When concerns are identified to the state/regional office, technical assistance needs are established and timeframes for the needed follow-up actions or additional reviews as appropriate.

g. How and when plans are updated, including when the participant's needs change?

Person Centered Plans are subject to continuous revision. However, at a minimum, the entire team performs a formal review at least annually. The case manager will maintain at least quarterly contact with each individual or their family or guardian. During quarterly contact, the case manager 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.

It is also the case manager's responsibility to review the provider's notes at least quarterly, and note any problems, discrepancies, dramatic changes or other occurrences that would indicate a need for renewed assessment. The case manager's review of the provider notes 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.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The team, through the development of profile information, brings out and documents elements of risk, and describes those actions and actors who will compensate for risk elements. This function is accomplished through profiles such as:

"What is important to me?" (the participant)

"What is my current health?" (with prompts for both positive and negative attributes)

"What are my daily routines?"

"What choices do I get to make?"

"What works for me and does not work for me?"

"What are our hopes and fears?" (Optional - used specifically to discuss risks)

"What are the barriers and opportunities?" (Optional - used specifically to discuss risks)

"What do the team and others need to know and do to support me?"

Information pulled into these profiles ("frames") may show several risks, but do so in the most objective, person centered way possible, without setting up a section for "problem behavior" or "risk abatement." When the team develops the action plan, and an objective is going to involve a degree of risk, the objective describes who is going to do what to minimize that risk, whether that be providing experiential learning for the participant, or paving the way by discussing issues beforehand with people with whom the participant is going to come into contact with, or ensuring that direct support staff have the necessary training and resources to support the participant in meeting the objective safely. The family and the provider QIDPs frequently take the lead in designing strategies to accommodate and mitigate risk.

In addition, an Individual Safety Assessment is completed during the plan meeting. This assessment addresses more straight forward risk factors such as ability to evacuate in case of a fire, ability to call for help, or does the person need special modification for emergency planning. Each individual should be trained and understand their emergency plan.

Each person should have an individualized emergency plan. People are supported to become knowledgeable about how to access emergency medical care and to access it as needed. Medication ordered by a physician to respond in a potential emergency is available in the appropriate dose, quantity and form. Organizations have emergency plans to deal with a variety of situations and accommodate the individual needs of people. Emergency contact numbers are readily available and accessible to staff and people receiving supports. Information (general topics) which will be discussed in a person-centered planning meeting is presented and communicated to the person in a method he/she understands and/or to the legally authorized representative prior to the scheduled meeting, except in the event an emergency meeting is necessary.

In addition to administrative requirements in Chapter 580-5-33-.3 through .10 and .12 through .13, the organization provides training to staff on the services to be provided and how the person wants to be supported. This training includes:

- (a) Review of the person-centered plan.
- (b) Information about the specific conditions and required supports of the person to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.
- (c) Reporting and record keeping requirements.
- (d) Procedures for arranging backup worker when needed.

A person-centered plan is developed and approved for the person receiving services; there is documentation establishing that the plan is followed and is modified as needed.

- (a) The person-centered plan is adequately detailed so that the worker can provide the services required by the individual.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

An individual coming into services, initially and after the person centered planning process, is provided information about services and supports by the 310/case management entity. Other providers and/or the Regional Office may also provide information, but the lead responsibility resides with the case manager. The individual and family verify their choice(s) of provider(s) by signing a document that lists that (those) choice(s). The individual and/or family/guardian are again provided information and an opportunity to exercise choice at the individual's annual review meeting. If the individual decides prior to the annual review meeting that he /she wants to change current services, a special team meeting is convened with Regional Office staff and/or a DMH Advocate included to address concerns and ensure information is provided about other available services and supports.

The Dissatisfaction of Services form is presented to each waiver participant and his/her family/representative as part of the planning process, and each participant or family/ representative must sign, acknowledging receipt of the information regarding his/her right to a hearing. The individual's signature on the free-choice of provider form, and on the plan of care, combined with the information presented in the Dissatisfaction of Services Form, assures the person is aware of his/her right to choose the services and providers he/she wants.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Medicaid nurses conduct a scientifically calculated random record review each month of all plans of care for persons initially enrolled or re-determined for waiver services during the previous month. These records are made available through the case management entity and the Regional Community Services Office. Service Plans are also required to be maintained by the service provider and can be made available upon request. In addition, Medicaid Quality Assurance staff perform a separate review of a random sample of plans of care and related documents annually for each provider, to assure the individuals receiving services under the waiver have a plan of care in effect for the period of time the services were provided. This review also ensures that the need for the services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The services and supports that are provided to an individual are based on a person centered plan (PCP) developed by a team.

Monitoring the implementation of the PCP and the participant's health and welfare is the responsibility of the direct service provider, members of the planning team as specified in the action plan (who is to follow-up on specific

objectives is spelled out in the PATH), the case manager, the Regional Community Services Office (RCSO), Certification staff, and Protection and Advocacy. The case manager reviews the services provided to an individual against the PCP on a quarterly basis. The case manager has an in-person follow-up with the individual at least once per quarter, and reviews individual satisfaction with the services provided, the adequacy of these services, and the individual's need or desire, if any, for the planning team to reconvene. If issues arise that adversely affects the individual's health or welfare, such as lack of staff based on the PCP, the Behavior Support Plan and/or the staffing plan, the case manager will notify the DMH Regional Community Services Office, which will intervene immediately.

The RCSO monitors both the implementation of the plan and the participant's health and welfare as part of the Participant-Centered Planning and Service Delivery waiver assurances. On an on-going basis the RCSO monitor will pull a sample of waiver participant's PCP to ensure compliance with the waiver which includes reviewing staffing patterns, ensuring individual emergency plans are being followed, and incidents are being reported. If there is an instance where staffing is inconsistent with the individual plan the RCSO monitoring report will summarize the findings, including notation if a plan of action is needed, if so when is it needed and what is it to cover, and notation of planned follow-up by the RCSO if needed, and when and how (in person, letter or telephone). The RCSO may request that an incident report be submitted for further review. If it is determined that the lack of staffing or emergency plan implementation put the participant at risk of harm to self or others then a "for cause review" by Certification staff can be requested.

The Certification staff reviews a sample of participant records, including the PCP and health and incident records, as a component of the comprehensive provider certification process. As part of the DDD certification process, Certification staff will review a sample size of individual records to ensure the individualized emergency plans are developed for everyone and address a variety of situations based on the person, as well as ways to accommodate the individual needs of that person. This falls under Best Possible Health. Best Possible Health requires 100% in order to receive a certificate to provide services. If this section is not passed with 100% then the provider will be placed on "Provisional" status and a plan of correction must be submitted and implemented. Once the plan of correction is approved the provider will receive a one year certification.

Finally, if a complaint or request for review is made to the ALDMH Internal Rights Protection and Advocacy Program and inadequate staffing or lack of implementation of an emergency plan is noted then the DDD will be asked to investigate.

**b. Monitoring Safeguards. *Select one:***

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

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

As described in a. above, every person on the team has a responsibility to monitor both plan implementation and participant health and welfare, and this includes both the QIDPs of the direct care provider and the case manager. However, the operating state agency also monitors both of these, as described, and in this way ensures that the best interest of the participant is safeguarded. While it is a function of the case manager to review the person-centered-plan and follow-up to ensure goals are being addressed, there are other layers of authority that review, monitor, and ensure plans are being implemented.

The DMH Regional Community Services Waiver Coordinator reviews participant's plans throughout the year to ensure the Operating Agency is meeting the required quality indicators as approved in the waiver document. Additionally, the Operating Agency's Certification personnel reviews a sample of participant's person-centered-plan as part of the site review. The Certification personnel will conduct a Positive Outcome Measures © survey to ensure the case manager is providing adequate services to meet the person's needs. The Basic Assurances Case Management Standards are listed below. In addition, focused conversations that include suggested questions are listed.

580-5-33-.15 Case Management Standards

Indicators:

A. The organization demonstrates the capacity to provide the core elements of case management.

- B. The case manager performs a written comprehensive face-to-face assessment of the person's assets, needs, supports, goals and preferences.
- C. The case manager coordinates planning.
- D. The case manager arranges services and supports.
- E. The case manager monitors services and supports.
- F. Documentation supports evaluation of the person-centered plan and promotes continuity of services and supports.
- G. The case management agency implements a system for transition/discharge planning.

Case Managers coordinate services and resources. The Case Manager is an agent who partners with the person to determine priorities and preferences for services. He or she assists the person in assessing needs, defining expected outcomes and developing or coordinating an outcome-based person-centered plan. The Case Manager locates services and resources that are consistent with the person's preferences, develops community linkage and monitors, reviews, and revises plans. The Case Manager will also seek out generic resources in the community. The Case Manager ensures, through this collaborative process, that the choices made by the person are actualized in the broader community.

#### FOCUSED CONVERSATIONS

Gather information directly from people to determine how they receive case management services. Here are some suggested questions for people and those who know them best. In addition, there are also some questions or areas the organization will want to address.

Suggested questions for the person:

1. What does your case manager do?
2. How does he/she help you?
3. How does that work for you?
4. Tell me about what happens when your case manager visits.
5. Are you satisfied with the services and supports you receive?
6. Are these the services you want?
7. Do you have enough services? Are they meeting your needs and expectations?
8. Can you change services or providers if you so choose?
9. How do you want your life to be in the future?
10. What is important to you to accomplish or learn?
11. Whom do you talk with about your future?
12. What are your hopes and dreams for yourself?
13. What assistance (if any) do you need to make these things happen?
14. What have you done that you feel good about?
15. What have you accomplished over the past few (one to three) years that has made you feel good about yourself?

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

#### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

#### i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

#### Performance Measures

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

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

**Performance Measure:**

**1. Number and percent of person centered plans that address all participants assessed needs (including health and safety risk). Percent equals the number of person centered plans that address all participants assessed needs divided by the number of person centered plans sampled.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**2. Number and percent of person centered plans that address all participants personal goals. Percent equals the number of plans that address all participants personal goals divided by the number of person centered plans sampled.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- b. **Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of service plans that are updated at least annual or revised as warranted by changes in the participants' needs. Percentage equals number of service plans updated or revised as needed divided by the number of sampled**

person centered plans.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

	Specify: <input type="text"/>
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- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of participants whose services are delivered in accordance with the service plan including type, scope, amount, duration, and frequency. Percent equals the number of participants whose services are delivered in accordance with the service plan including type, scope, amount, duration, and frequency divided by the number of sampled plans.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of sampled participants who were afforded choice between/among waiver services and providers. Percent equals number of sampled participants with documentation of choice of waiver services and provider divided by total number of sampled participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

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v

**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 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; text-align: right; padding-right: 5px;"> <span style="font-size: 12px;">^</span>  <span style="font-size: 12px;">v</span> </div>	<input type="checkbox"/> Annually
<input type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; text-align: right; padding-right: 5px;"> <span style="font-size: 12px;">^</span>  <span style="font-size: 12px;">v</span> </div>	

**c. Timelines**

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

No

Yes

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

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## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants in the waiver will be offered an opportunity to self-direct services as the common law employer of record with budgetary authority if there is sufficient support available. A participant may self-direct select supports and services and also receive traditional supports and services from a provider agency, as long as both services are in the plan of care and are not duplicative. Self directed services include hourly support (Personal Care, Companion Care, and Community Experience), nursing (RN, LPN), therapy (Physical, Speech, Occupational, Positive Behavior Supports), and Specialized Medical Supplies, Equipment, Accessibility Augmentation, PERS, and Individual Goods and Services for further supports and maintenance.

Participants who self-direct either RN or LPN services, do so at the standard rates for these waiver services, to train and monitor any Personal Care assistant activity which may only be provided with delegation from a nurse. This would include assisting a consumer with the administration of ordinarily self-administered medications. The activities which may be delegated are dictated by the rules of the State Board of Nursing. The hours of nurse service necessary for this function must be specified in the plan of care and will be prior authorized. Using this service in this way, for nurse delegation, may only be used by participants who self-direct, and is not available for certified providers because the funding is already included in the rate paid to the providers.

Similarly, participants who self-direct Positive Behavior Supports will do so under the supervision of the Director of Psychological and Behavioral Health Services (or designee). This service required supervision at the technician level as well as significant documentation to ensure proper implementation and modification or fading of the plan.

Each participant may select self-directed services, or request more information about it, during the initial and each subsequent planning meeting. New entrants to the waiver will thereby be offered the opportunity from the beginning, and individuals already enrolled in the waiver and receiving services will be offered the opportunity no later than their next team meeting, which occurs, at a minimum, once per year. Case managers and Regional Office staff will be able to answer questions about the service option, and provide general written information, and if a participant or his/her family wants more information before making a choice, there will be contracted liaisons available to provide it in each region of the state.

A fiscal intermediary (Financial Management Service Agency or FMSA) will be available for each participant who chooses to self-direct services. The FMSA will be paid as an administrative cost. In addition to the services of the FMSA, participants who self-direct will have an information and assistance liaison available, also reimbursed as an administrative cost, who will be able to inform and consult, intervene, and trouble shoot any problems the participant may have. The liaison model is adopted as an initial step. Once participation in self direction expands and experience is gained statewide, the waiver service of Community Specialist will be used for this purpose, and self-directing participants will be able to employ any Community Specialist of their choice. This service, which is already approved in the waiver, must by definition be free of conflict of interest, and there are very few stand-alone practitioners at present who also have the necessary knowledge of the mechanics of self-direction to provide all participants all the support they will need. Therefore, until the number of Community Specialist increase, an administrative self-directed liaison will be available for each person or family who wants to self-direct.

Participants who select self-direction will have a budget based on the support team's planned services. Units of service will be authorized and converted into a dollar amount. The participant will manage their services, with the assistance of the FMSA and self directed liaison, by setting the employee rate, utilizing unused dollars to purchase more self-directed services if desired, covering the cost of overtime reimbursement (if applicable), purchasing worker's compensation insurance, or utilizing Individual Goods and Services when appropriate.

Individual Directed Goods and Services can be accessed with accompanying self-directed waiver services and procured through the participant's savings account maintained by the FMSA. The reimbursement or purchase of goods and services on behalf of the waiver participant will be made through the FMSA. When reimbursing the participant a valid receipt will be needed. If the participant cannot pay for the good or service up front then the FMSA will work out a process to procure a receipt and pay the vendor in advance. A valid receipt will be sent to the self-directed liaison to ensure the good or service was rendered or received.

Utilization will be reviewed routinely to ensure authorized dollars are being appropriately allocated to ensure health, safety, and welfare of the participant. Under utilization of dollars will be reviewed on an individual basis. Budgets will be reviewed annually and adjusted up or down based on utilization and needs.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

*Specify the criteria*

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information describing benefits, responsibilities and liabilities, together with an overview of the FMSA role and process, will be available in a brochure and on the Operating Agency's web site. This information will also describe how waiver participants and/or their families can find more information and go about accessing the service. The brochures will be provided to case managers to take with them to all planning meetings, so that they may share the information with participants and team members. Once an individual and/or family indicates interest at a planning meeting, a referral will be made to the self directed liaison for that region to make contact with the person and/or family and explain, in detail, the entire process. If the person / family wish to proceed, the liaison will provide them with a manual and a packet of forms, which he or she will help them complete, will explain the budget and budget process, and will initiate the referral to the FMSA with notification to the regional office.

## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representative may include family members with whom the participant lives, with no special requirements. For individuals who live in their own private residence and need to designate a representative, some special requirements will apply. A representative has to be able to assure the Regional Office that he or she has no conflict of interest and will support the participant's best interests. Second, there must be evidence that he or she is competent, willing and able to fulfill all the responsibilities, including providing sufficiently close supervision to a) assure the participant's health and welfare and b) sign the worker's timesheets with assurance each timesheet is accurate and truthful. Third, the representative must be chosen by the participant, but can neither be paid for being a representative nor be someone who is paid to provide any other service to the participant.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Speech and Language Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Occupational Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Experience	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Positive Behavior Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Emergency Response System	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Specialist Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Accessibility Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

- h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
- Private entities**
- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**  
*Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

#### Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The Financial Management Service Agency (FMSA) was originally procured through a competitive RFP issued by the Alabama Department of Senior Services to administer Alabama's 1915(j) program. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities. The Department of Mental Health issued its own competitive RFP for the FMSA services when self direction was added to this waiver. Based on experience, cost, and references the Department of Mental Health selected the same vendor used by AL Department of Senior Services. Each contract is set for two years then the RFP process has to be completed again.

PMPM cost for FMS services is based on the number of participants enrolled. AL DDD has less than 100 enrollees. The cost for initial set-up for a participant is \$75 and the monthly cost is \$90.

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

The payments for the services provided by the FMSA will be based on an invoice submitted monthly. Payments are calculated according to a per-participant-per-month fee schedule. The fee is for a variety of activities specified in the vendor contract, and the fee is the same for every participant for whom an activity is provided during the month.

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

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

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

*Specify:*

The FMSA furnishes background checks on prospective employees.  
 The FMSA assures prospective employees meet waiver requirements.  
 The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.  
 The FMSA will procure goods and/or services on behalf of the participant.  
 The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis.  
 The FMS will also report budget balances to the regional office and self directed liaison.

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Supports furnished when the participant exercises budget authority:

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

*Specify:*

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Additional functions/activities:

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

*Specify:*

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

The FMSA will provide reports and documentation to the Regional Office and the self-directed liaison, of the self-directing participants, that will identify the amounts paid to and on behalf of employees and include copies of the signed time sheets for those employees for each pay period. The reimbursement to the FMSA will be based on the timecard submissions. If there has been an error in timecard submissions then the error will be corrected by the following pay period. The self-directed liaison will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood.

The Regional Office, working with the FMSA, closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the self-directed liaison and receipts for items paid for up front by the FMSA will be reconciled by the liaison.

## Appendix E: Participant Direction of Services

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

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

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

Case managers will have sufficient training and printed information to explain in general the self directed option to families and participants. If the family is interested in this option, the case manager will notify the Operating Agency Regional Office, which will notify liaison to make contact with the family and participant and explain the option in greater detail. As more families and participants express interest in self-direction, case managers will become more knowledgeable about the details, and thus more helpful.

The self-directed liaison is an essential link to families and waiver participants who are interested in self-directing services. The program remains small but is growing nonetheless. There is printed material that is available on line but word of mouth has been the most effective way of informing people about the program. Case managers are working closely with the self-directed liaison during the initial phase. Case managers will have a team meeting and services will be transferred from “traditional” to “self-directed”. Also included in this is the process for establishing a budget for the person. All these pieces work together to establish a person into self-directed services.

The DDD has developed a self-directed work group comprised of caregivers and OA staff. This workgroup is intended to identify strengths and weaknesses in the program and offer suggestions.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	<input type="checkbox"/>
Speech and Language Therapy	<input type="checkbox"/>
Individual Directed Goods and Services	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Residential Habilitation Other Living Arrangement (OLA)	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
Housing Stabilization Service	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Benefits and Career Counseling	<input type="checkbox"/>
Community Experience	<input type="checkbox"/>
Positive Behavior Support	<input type="checkbox"/>
Supported Employment Emergency Transportation	<input type="checkbox"/>
Crisis Intervention	<input type="checkbox"/>

Personal Emergency Response System	<input type="checkbox"/>
Employment Support	<input type="checkbox"/>
Specialized Medical Supplies	<input type="checkbox"/>
Community Specialist Services	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>

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

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

Because Self-Direction is a relatively new option in this waiver, most case managers and providers don't know enough about it to really help a family or participant decide if they want to try it or not. As a consequence, the Operating Agency will contract with a limited number of individuals who have knowledge and experience in the field of Intellectual Disabilities, who have no conflict of interest, and who are willing to be trained to provide detailed information and day-to-day support to families and participants who indicate an interest in using this service option.

The contracted individuals (self-directed liaisons) will be paid a standard rate per hour plus travel expenses. Their costs will be covered as an administrative expense. They will be trained by state staff and by the FMSA, in order to have the detailed knowledge with which to assist participants and their families. The supports for the self directed option consist of explaining the benefits and costs (requirements) to the family or participant, explaining how the process works, and exactly what the self directed option entails in terms of responsibility and liability. This discussion ranges from recruiting, hiring, supervising and possibly firing staff, to keeping time sheets, developing backup plans, managing their staff within the funds available, and how to utilize the Goods and Services waiver service. When the family and / or participant choose(s) to proceed, the contracted liaison (consultant) will provide the packet of needed forms and explain and demonstrate each one. This is extremely detailed, and the family may ask the liaison to help them fill the forms out. Additionally, the budget will be discussed.

The liaison may return to the family as often as necessary to set up the system. The liaison, regional office, and the FMSA will collaborate to ensure the processes are in place to assure the health and welfare of participants, and to ensure that payments and services are legal and sufficient.

The liaisons will meet with the Operating Agency on a routine bases to review and approve their work. The liaisons will track and document all services rendered based on the scope of their contract and invoice the Department for their time. They may also be asked to consult with the regional office and / or the FMSA about progress or problems in any particular situation. Any concerns regarding the effectiveness of a liaison will be brought to the attention of Operating Agency's central office. The final review element for the liaison's performance is the family or participant. They will be communicating directly with the regional office, and with a case manager, and if they wish, an advocate, so any problem they may experience with the liaison can and should be reported through those channels.

The Self-Directed Liaison (SDL) is an essential link to families and waiver participants who are interested in self-directing services. The program remains small but is growing nonetheless. There is printed material available online but word of mouth has been the most effective way of informing people about the

program. Case managers work closely with the SDL during the initial phase of self-directed enrollment. Case managers will have a team meeting and services will be transferred from “traditional” to “self-directed”. Also included is the process for establishing a budget for the person. All these pieces work together to establish a person into self-directed services.

It is the responsibility of the SDL to provide assistance to anyone interested in self-directing services. This includes identifying the services that can be directed, informing interested parties about their role and responsibility (i.e. timecard submission, documentation, etc.), communicating with participants and notifying case management or the region and central offices of any concerns, and assisting participants with their budget. The SDL is generally the first person that a caregiver contacts with concerns and the SDL then reports issues to the appropriate source.

The DDD has developed a self-directed work group comprised of caregivers and participants', OA staff and the SDL. This workgroup is intended to identify strengths and weaknesses in the program and offer suggestions for improving services that are self-directed.

The SDL works with the fiscal management agency as well. Working with the participant and caregivers, the SDL ensures that time cards are submitted correctly, that the individualized budget is submitted, and provides notification and technical assistance to anyone participating in the program.

Finally, the SDL is working with the Director of Case Management to develop standard protocol across the state for case managers to follow as self-directed services grows throughout the state.

## Appendix E: Participant Direction of Services

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### E-1: Overview (10 of 13)

#### k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

The Alabama Department of Mental Health operates an advocacy program independent of the Division of Developmental Disabilities (the Operating Agency). This program monitors participants to ensure their rights are not violated and operates a toll-free Advocacy Access Line during normal state business hours and a voice mail response system for after-hour callers for participants to request assistance or report issues. The number for this hotline is provided to all participants upon entry to the waiver program and will also be included with the brochure and manual provided to self-directing participants.

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

1. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Any participant who is self-directing his or her services may request to discontinue this model at any time by contacting the case manager, liaison, or the regional office, all of which will notify the Operating Agency immediately. The case manager will provide the participant with free choice of providers who will take over delivering the services. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the provider agency which is selected. The transfer will be as fast as can be arranged depending on the circumstances: if the participant's staff can be employed by an agency to continue the service, this will be done within two weeks. If all new staff needs to be recruited, vetted, hired and trained prior to employment, the process

may take a month or more. During that time the original backup plan will need to be implemented, and other providers within the county may also be asked to help staff the participant's needs.

The circumstances under which a participant chooses to voluntarily terminate his/her use of the self-direction model will always be assessed, first by the case manager, then as needed, by the regional office or advocacy section, as a routine component of trying to improve the service delivery system.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be discharged involuntarily from participant direction because of:

1. Health or Welfare issues: the participant's and/or family's desire to continue self-directing will always be considered primary, but the case manager, liaison, or regional office will report adverse information to the Operating Agency, and if in the considered judgment of the Operating Agency the participant's health or welfare is in jeopardy, for any reason from abuse to change of condition, that individual will be returned to a traditional form of services.
2. Consistent participant failure to correctly utilize the FMSA services to pay his or her staff, after efforts have been made to provide support and training and have repeatedly failed, will result in termination of self-direction and return to a traditional form of services. Likewise, a participant who consistently discharges staff and ultimately is unable to hire anyone will also be returned to traditional services.
3. Anyone who engages in false approval and reporting of time cards, or in any other way acts to deceive or defraud, will be terminated from self-direction. If the person engaging in the fraud was not the waiver participant, referral will be made to the Medicaid Fraud Unit. If that person was the waiver participant, he or she will simply be returned to traditional services.
4. The method of returning a person to traditional services when they are involuntarily terminated from self-direction is the same as the method used when a person is voluntarily terminated. The case manager will provide the participant with free choice of providers who will take over delivering the services, unless it happens that a new service configuration is needed. For example, it may be necessary for the individual to move to a group home, either for care of an accelerated health condition or because the previous setting was exploitive. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the new provider agency, but that will depend on the conditions that led to the termination. The transfer will be as fast as can be arranged depending on the circumstances: if the transition is prolonged, respite will be used as a bridge.
5. Participants who are terminated from self-direction are not provided the opportunity for a Medicaid fair hearing, because self-direction is only one method of receiving the services as long as the participant can be and is transitioned to the same essential set of services and his or her needs are met, no adverse action has occurred.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	9 <input type="text"/>

Year 2	<input type="text"/>	<input type="text" value="15"/>
Year 3	<input type="text"/>	<input type="text" value="21"/>
Year 4	<input type="text"/>	<input type="text" value="27"/>
Year 5	<input type="text"/>	<input type="text" value="33"/>

## Appendix E: Participant Direction of Services

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

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

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

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

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

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

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

Specify how the costs of such investigations are compensated:

The FMSA will provide a background check to the participant and/or representative as a component of the administrative service for which it is paid.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**

- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

## Appendix E: Participant Direction of Services

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

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

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

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

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

The self-directed global budget will be developed based on authorized units from the individual's service plan. The process for developing the service plan will not be different from that of traditional waiver services. The individual's support team will meet and develop the person-centered plan based on expressed desires and needs. Based on specified goals and needs for support, a service plan will be developed with units of service assigned to each waiver service. The service plan can include both traditional waiver services and self-directed services. The authorized units for self-directed services will be converted to a dollar amount that represents the individual's budget for the year. If the individual chooses to self-direct all services then the person-centered planning process would be slightly different. If possible the person and his/her parent/guardian/representative of choice would develop a person centered plan. If this is not feasible then the self directed liaison would develop the person centered plan.

The individual will have the ability to hire staff (approved by the FMSA), establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Directed Goods and Services service for items needed to help promote inclusion in the community, decrease reliance on Medicaid services, or increase safety in the home so long as the service or good is not otherwise reimbursable through the waiver or Medicaid. Any dollars saved through wage negotiations can be applied to the Goods and Services service up to the cap.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

Due to the fact that this waiver already affords the self-direction Employer on Record option extensive effort has already been spent informing the public about the self-directed option. Information about self-directed services, employer on record, and budget authority will again be made public through various ways. An informational pamphlet will be redesigned, distributed to case management agencies, as well as posted on the Department of Mental Health's web-site describing the budget authority principles. In addition, advocacy groups such as ADAP and consumer empowerment organizations such as People First will be informed of the updates to the self-directed options. Finally, statewide training will be conducted to inform the public of what self-directed services mean, how the budget authority functions, as well as the process for building an individualized budget.

The individual will be notified of their self directed services during the service plan development process. The plan development process requires signatures of all members of the support team, including the individual if able, indicating the services have been reviewed and all involved are in agreement. The self directed services budget amount will be determined and the participant will be informed during the enrollment meeting with the liaison. Requests for adjustments to the self directed services budget will go through the liaison. Request will be made to and approved by the regional office. The Operating Agency will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate, employee overtime payment, employee bonuses etc. The self-directed budget does not serve as a limit on the amount of waiver services that an individual may receive. The support team will determine the appropriate level of service and the self directed services budget will be built based on maximum units authorized. Budget changes will not be approved for purchase of waiver goods and services not authorized in the service plan.

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards for preventing premature depletion of the individual's budget are multi-layered. First, each Regional Office will be responsible for maintaining individual budget data based on time card submissions and other financial data provided by the FMSA. Individual Goods and Services will only be authorized by the liaison and Regional Office if there is enough savings in the individual's budget and there is not a concern of premature depletion. The FMSA will maintain the individual's budget and savings account and will monitor it monthly to ensure utilization remains steady. Individual balance reports will be generated monthly and submitted to the Regional Office and liaison for review. If there appears to be either overutilization or underutilization, the liaison will contact the participant to outline their concerns. If either over utilization or underutilization is an on-going problem, the individual and representative will be consulted and informed of the possibility of involuntary discharge of self-directed services, and a transfer to traditional waiver services will be made.

## Appendix F: Participant Rights

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### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the operating agency adversely affects his/her eligibility status or receipt of service. If an applicant is determined not eligible by the operating agency, he or she is provided with notification of the determination, the reason and authority for the determination, and an explanation of the appeal rights and procedures available to the applicant. The formal process of notification and appeal is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama

Medicaid Administrative Code. There is an appeal process conducted by the operating agency at the applicant's choice, with the right to further appeal to the Medicaid Agency being explained to the applicant. If an appeal is made to the Medicaid Agency, a hearing officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings. Medicaid legal counsel will be responsible for taking a lead role in the fair hearing process. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

Waiver recipients are provided with the necessary information regarding their opportunities to request a fair hearing as part of the planning process, by receiving and signing the Dissatisfaction of Services form. This form contains the information regarding his/her right to a hearing and acknowledges receipt of it.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the person's treatment team discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/representative.

Whenever there is a decision by the operating agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Department of Mental Health (DMH) will issue a written notice to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. This notification and the Dissatisfaction of Services form referenced above can be obtained from the operating agency.

Per DMH Administrative Code, the following grievance/complaint regulations apply to all contracted providers of waiver services

The organization has a mechanism that provides people supported and their legally authorized representatives with information regarding filing complaints and grievances. At a minimum, the complaints/grievance procedures include the name and telephone number of a designated local contact within the organization.

The designated local contact has the knowledge to inform persons, families and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.

Grievance procedure information is available in frequently used areas, particularly where people receive services. Such notices include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.

The organization provides access to persons and advocates, including a DMH internal advocate and the grievance process without reprisal.

Responses to grievances/complaints are provided within a timely manner as specified in the agency's procedures and in a manner that the person can understand.

The organization implements a system to periodically, but at least annually, review all grievances and complaints for quality assurance purposes.

Within ninety (90) days of employment, all employees who directly provide supports to people receive training in the following areas: Rights of people served, to include the recipient complaint/grievance procedure.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Division of Developmental Disabilities, which is one division of the Alabama Department of Mental Health, is the Operating Agency for this waiver program. The notice of adverse action mentioned in Appendix F-1 includes an optional appeal to the Associate Commissioner of the Division of Developmental Disabilities. The consumer/family has the option to appeal in writing to the Associate Commissioner, who will arrange an appeal review, after which she or he will issue a decision within 21 calendar days. The notice also states that if the consumer/family disagrees with the Associate Commissioner's decision, they may appeal to the Medicaid Agency, and the notice indicates how and by when to do that.

The process will include a thorough review of all documents submitted with the initial application and may also include requests for additional information.

The types of disputes which can be addressed through this process include any adverse actions which have required the notice of due process to be sent to the consumer/family. Participation in this process is at the option of the consumer/family. If they choose not to participate, they may send their request for appeal directly to the Medicaid Agency.

In the rare instance that the adverse action includes terminating a service or dis-enrolling a person from the waiver who does not want to be dis-enrolled, the service will be continued until a review can be held, if the person appeals within the fifteen calendar days prior of the effective date of the notice.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Alabama Department of Mental Health, Office of Advocacy Services

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department maintains an independent office of advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of AL business hours (the number is required to be posted in every certified site and given to each consumer), and investigates or causes to be investigated any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories: a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h) Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; l) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.

Complaints of abuse, neglect or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than 7 working days of the report, with the expectation that the investigation will be completed within 30 working days.

Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy Program or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the consumer. If the consumer is receiving services under the waiver and his complaint involves waiver related issues, and he cannot achieve satisfaction through the required resolution, he and his representative are referred to the Medicaid Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services can resolve most problems.

Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, and if warranted, a notation of the resolution. These reports are provided to the staff of the Alabama Medicaid Agency

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

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

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- No. This Appendix does not apply** (*do not complete Items b through e*)  
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

State Critical Event or Incident Reporting Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Exploitation	Immediate
Moderate Injury	24-hours
Major Injury	24-hours
Choking	24-hours
Fall	24-hours
Seizure	24-hours
Other	24-hours
Medication Error Level I	Monthly

Medication Error Level II	Monthly	
Medication Documentation Error		Monthly
Medication Error Level III	24-hours	
Missing/Eloped Consumer		Immediate
Death		Immediate
Severe Behavior Problem	24-hours	
Natural disaster	24-hours	
Fire	24-hours	
Physical Assault	24-hours	
Sexual Contact	24-hours	
Manual Restraint (Emergency)	24-hours	
Mechanical Restraint (Emergency)		24-hours
Chemical Restraint	24-hours	

All DMH certified community providers shall report incidents involving consumers that occur in operated or contracted community residential and day programs, either on the provider's premises and or while involved in an event supervised by the provider for all recipients of services. Reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with families).

#### Administrative Code Regulations:

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation

Each entity shall have a written plan that addresses the process of prevention and management of incidents.

The Division of Developmental Disabilities (DDD) preserves the safety, protection, and well being of all individuals receiving services through its certified community agencies, and will take appropriate action on any mistreatment, neglect, abuse or exploitation of those individuals.

The DDD prohibits abuse, neglect, mistreatment and exploitation of individuals served, and has procedures for investigating and reporting such incidents, and for taking disciplinary and corrective actions.

The DDD has promulgated a Community Incident Prevention and Management Plan that provides guidance for community agencies/providers in the implementation of incident prevention and management systems to protect individuals from potential harm, and those agencies are required to implement this Plan as part of their DMH certification requirements.

All certified agencies are required to implement a Community Incident Prevention and Management Plan (IPMS) as required by the Division of Developmental Disabilities, to protect individuals served from harm and improve the agency's responsiveness to incidents for the purposes of prevention of harm and risk management.

Each certified agency must notify DDD of all reportable incidents and take actions in accordance with the Community IPMS requirements, which include state law and funding source requirements.

Each certified agency shall make changes/enhancements in the agency's Basic Assurances Plan as required by DDD to incorporate innovative strategies for the prevention and management of incidents, to address incident trends, and to update requirements of state law.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

#### Participant Training and Education

Each person served by a provider agency is required by regulation to be informed of his rights and responsibilities annually. Rights include being free from abuse, neglect and exploitation. Each person is also informed of the Office of Advocacy toll-free hotline, its purpose and its number. Each person is also informed by the provider of his due process rights. Case managers maintain relationships with individuals to encourage them to talk about what is important to them, including what may be happening that they don't like. The Office of Advocacy Services of the Department of Mental Health conducts routine random monitoring, and Regional Offices of the Division of

Developmental Disabilities conduct routine monitoring, both of which monitoring processes include talking with individuals.

Administrative Code Regulations:

580-5-33-.04 Promotion and Protection of Individual Rights

The organization implements a policy and procedure that clearly defines its commitment to and addresses the promotion and protection of individual rights of people.

The policy lists rights afforded all citizens as indicated by the United Nation's Declaration of Human Rights, by the constitution, laws of the Country and State of Alabama.

The policies and procedures describe the organization's required due process that includes a Human Rights Committee review and documentation of all proposed restriction of a person's rights.

The organization has no standing policies or procedures that restrict individual rights without due process.

The organization documents upon admission and annually thereafter, verification that it provides to persons and their legally authorized representatives an oral and written summary of rights/responsibilities and how to exercise them, in language that the person understands.

Each person's ability to understand and exercise his or her rights is assessed and updated on an ongoing basis but at least annually.

Every person shall have the right to due process with regards to complaints/grievances and rights restrictions, within the agency or program providing services. Due Process is, for these purposes, defined as providing the consumer, and/or their family or guardian, with a fair process that requires, at least, an opportunity to present objections to the proposed action being contemplated.

At a minimum, the complaint/grievance procedures shall include:

- (a) The name and telephone number of a designated local contact within the entity.
- (b) The designated person shall be able to inform persons of the means of filing grievances and of accessing advocates, ombudsmen, or rights protection services within or outside the agency.
- (c) Grievance procedure information shall be available in frequently used areas, particularly where people receive services. Such notices shall include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.
- (d) Agency shall provide access to advocates, including a DMH internal advocate, and the grievance/complaint process without reprisal.

Procedures for the initiation, review and resolution of complaints and grievances shall be explained to the consumer/advocate and legal guardian.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities

Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-5-33-.04.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

Additionally, the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

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

The Regional Director for the Division of Developmental Disabilities, or designee, will review each incident report for each reportable incident described in G-1 a. and determine if the report requires no action follow-up, action follow-up, or an investigation. All allegations of abuse, neglect, mistreatment, or exploitation are incidents that, by regulation, require an investigation. Other incidents may or may not require an investigation, based on the nature of the incident and action already taken by the provider. Nonetheless, all defined incidents must be reported, by the regulations governing certification of providers. Specifically, the provider is required to first assure the participant is safe and being treated as necessary, then report the incident, assess the cause, impact and needed actions regarding the incident, and address the needs so determined. The Regional Office reviews the provider' actions, as reported, to determine their adequacy.

Each Regional Office has a lead staff whose primary function is Incident Prevention and Management. This staff will have other staff of the Division available to assist as needed: for instance, certification, advocacy and Quality Enhancement staff are available, as is a registered nurse. A physician, psychiatrist and behavior analyst are also available on call (these are located in 3 of the 5 regional offices). In addition, the designated staff can involve other professionals in the Regional Office who routinely monitor the provider in question, and anyone else who knows the participant, such as the case manager.

If the information submitted by the provider regarding an incident is sufficient to determine a. the person is safe, b. the issues have been resolved, c. if the person needed anything more he is receiving it, d. an analysis has been conducted to determine if the incident could have been prevented, and e. that an analysis has been made to determine if there is a pattern that needs to be addressed, the designated staff will document this with a recommendation to the Regional Director that the incident requires no action follow-up. If the staff recommends, and the Regional Director determines, that an incident requires action follow-up, then the designated staff will coordinate the efforts. Additional staff can be involved as mentioned above, and additional information is gathered either directly by the regional staff or through the provider. The Regional Office can and does assign actions to the provider, with timelines. Completion dates are not to exceed 60 days based on the nature of the incident.

If more information is required of an investigation, it has heightened scrutiny, and the Regional Office can expand an investigation. For example, the Regional Office can initiate its own investigation if they suspect the provider is not doing an adequate job, or has a track record of insufficient investigations, or has a clear conflict of interest. Also, the Regional Office will notify local law enforcement of possible criminal activity, if the provider has not done so and the information warrants it. Other entities that are routinely notified include DMH's Advocacy Office and the Adult Protective Services Unit of the Department of Human Resources. Investigation procedures have been trained and are retrained periodically, both for providers and for Regional Offices. Investigations must be closed within 60-days, unless there are extenuating circumstances, such as the absence of a necessary witness, or when repeated efforts to get information from the provider are required. Certification of the provider includes a review of the provider's compliance with incident reporting, management and investigation, and failure to cooperate results in lowered certification scores, which will cause the provider to be placed on provisional certification.

Participants are not routinely sent information by the DMH, regarding the status or outcome of an investigation. Rather, the provider will usually talk with the participant to explain any changes in his services that happen because

of an investigation, and will discuss the allegation and finding in more detail with a participant who will be able to understand what he or she is being told. Family members and other guardians will also usually be told the outcome by the provider, and by the case manager. In addition, the participant, his family or his guardian may request a written summary of the investigation report, which the DMH will provide.

Documentation of actions by the provider, by the Regional Office, and by others is maintained in a database at the DMH. This information is used to discern patterns and determine systemic interventions, as described in Appendix H.

Administrative Code Regulations: Each was summarized under G-1 a. above

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Alabama Department of Mental Health

--Division of Developmental Disabilities Central and Regional Offices

--Office of Advocacy Services

Alabama Department of Human Resources (certain incidents of abuse, neglect and exploitation must be reported to ADHR by law).

Alabama Medicaid Agency: annual review of DDDs investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews. Quarterly review of Advocacy's reports.

Individual providers are required to report incidents to the perspective community service office (RCS). If the provider has provided sufficient information and corrective action, then the incident is closed. If the RCS office determines that additional information is required, then a Request for Action form is forwarded to the provider agency, additional info is submitted to the RCS office and the incident is closed. If the incident requires an investigation, the RCS may require the provider agency to conduct the investigation, rely on DHR and/or local authorities or Internal Advocacy, or conduct the investigation themselves. The RCS office Director reviews all investigation for completion and thoroughness. Any additional corrective action needs are requested of the provider and followed-up until complete. Additionally, all investigation initiations and completions are forwarded to the Office of Quality and Planning for additional review and approval. Medicaid is informed of critical incidents that are systemic or otherwise rise to the level of decertification. Quarterly operating agency meetings are conducted by Medicaid in which providers on "provisional certification status" for violations of Best Possible Health, Protection from Abuse, Neglect, Mistreatment, and Exploitation and Safe Environments are discussed and actions being taken. Finally, Medicaid completes an annual audit of case management agencies and their sub-contractors to review ADMHs certification process and needed follow-up.

Incident reports are submitted to the Regional Offices and entered into the IPMS system. These incidents are tracked by regional staff to completion and closure. In addition to the above, Regional QE Staff (1 in each of 5 regions) compile and analyze data on a quarterly basis for their region to identify any problematic trends or patterns. Individual provider and recipient issues identified are managed administratively by the regional office staff. Systemic educational development and training needs are managed by the QE staff. Also, on a quarterly basis, the Director of Quality and Planning compiles and analyzes data on a statewide basis and presents to the Developmental Disabilities Sub-coordinating Committee, a statewide stakeholder group, that makes remedial recommendations as needed to the Associate Commissioner for DD Services.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Behavioral Services Procedural Guidelines describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. Providers are required to train all staff who must implement restraints in the appropriate application of the procedures. If a person is found to be implementing the restraint incorrectly or outside the boundaries of an individual's Behavior Support Plan (BSP), whoever witnesses the event is obligated to report it and the provider is required to submit an incident report and conduct an investigation regarding the inappropriate use, misuse, or unauthorized use of restraint. The Regional Community Services offices review any instances of this and follows up on the investigation, adding recommendations when necessary to those implemented by the provider to remedy the situation and prevent further occurrence. Any Emergency use of Restraint must be reported via the Incident Prevention and Management System (IPMS) procedures. If 3 of these occur within a 6 month period, the team is required to meet to determine the factors leading to the need for those restraints in order to determine what alternatives could have been tried more effectively and evaluate whether restraints should be added to the person's Behavior Support Plan (BSP). Additionally, at any time that Regional Office staff are conducting their usual monitoring of providers and they witness or become aware that any restraint has been used without authorization, it is reported and investigated. Finally, certification staff routinely reviews the use of any restrictive procedure during surveys to ensure appropriateness and adequate due process.

Every staff person who works with an individual for whom restraints are a part of their BSP must receive specific training regarding how to implement the restraint and under what circumstances the restraint can and cannot be used before they can work with the person. All provider direct support professionals, QDDPs, and others must receive training in the Management of Aggressive and severe challenging behavior as part of their orientation training as well as annual refreshers. Professional staff must also have that kind of training. Direct Support Professionals are required to have a high school education, the QDDP must have a minimum of a bachelor's degree as well as training on the Behavioral Guidelines. Most of the providers who contract with the division do not use restraints. Most of the agencies that serve individuals who require restraints, either employ or contract with a Board Certified Behavior Analyst. Emergency use of restraints requires authorization from a QDDP, Program Director, or Physician. Direct Support Professionals cannot just decide to implement a restraint without that authorization.

Manual Restraints are listed in the behavioral guidelines as a Level 3 procedure in a BSP, which requires approval by the individual and his/her team, the Behavior Program Review Committee (BPRC), the Human Rights Committee (HRC). Mechanical Restraints are listed in the guidelines as a Level 4 (most restrictive) procedure in a BSP, which requires all of the previously listed reviews/approvals and must also be submitted for approval by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities. The DPBS determines the frequency of additional reviews that will be required on a case by case basis for these Level 4 BSPs. Reviews by both the BPRC and HRC committees include that they ascertain whether less restrictive procedures have been tried and documented to have been ineffective prior to approving restrictive procedures, including restraints.

Per the Behavioral Services Procedural Guidelines, Level 3 Procedures are restrictive and may only be used by direct care professionals when they are included in a Behavior Support Plan (BSP). Some of the procedures may be used in emergency situations and are so designated. Emergency use of these procedures requires an order from a QIDP. The use of an Emergency Procedure three times in a six

month period requires the individuals planning team to meet, within five working days of the third use, to determine if a BSP is needed. The team's determination must be documented. Staff must be trained in the use of these procedures prior to using. Each BSP containing Level 3 Procedures requires prior approval by the Behavior Program Review Committee (BPRC), review by the Human Rights Committee (HRC), and approval/consent by the individual or the parent/guardian, and must be reviewed and updated at least annually.

Level 4 Procedures are considered the most restrictive and must be in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding the number of times it can be used). Each BSP containing Level 4 Procedures must be reviewed by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities, the BPRC, the HRC, and approval/consent by the individual or the parent/guardian. Requests for the use of these procedures should be sent to the DPBS at the same time that consent requests are sent to the parent/guardian. The DPBS or designee will review and respond within two (2) working days of receipt of the BSP with the Level 4 Procedure. Staff must be trained in the use of approved procedures prior to using. The frequency for review and updating of the BSP with Level 4 Procedures will be indicated in the response sent by the DPBS or designee, however a review is required at least annually.

Manual, Mechanical and Chemical Restraints are permitted in emergency situations and as procedures in properly designed and professionally monitored behavior support plans and implemented by trained staff, as follows.

There are two types of restraint recognized in community programs: Emergency and Programmatic. Emergency restraint includes:

1. Manual: the use of physical holding of an individual so there is a restriction of movement that lasts for more than five consecutive seconds and there is Behavior Support Plan authorizing these procedures.
2. Chemical (psychotropic medication): the use of medication(s) to control behavior when there is no BSP or Medication Plan. Other strategies of intervention and/or containment have been tried, but were unsuccessful. Authorization for the medication is made by a Physician.
3. Mechanical: the restriction of an individual's movement by mechanical means in an emergency situation and not outlined in a BSP. Includes arm splints, wrist cuffs, four and five point restraint.

Programmatic restraint includes:

1. Manual: the use of restraint as defined above except that the procedure is part of an approved Behavior Support Plan.
2. Chemical (psychotropic medication) is the use of medication(s) to reduce or change behavior associated with psychiatric symptoms that are authorized by the individual's Behavior Support Plan (BSP) and/or Medication Plan.
3. Mechanical: the restriction as defined above except use of this procedure requires special documentation and authorization minimally by professional supervisory personnel.

#### Positive Behavior and Support

Administrative Code 580-5-33-.11

Objectives and strategies are developed to address behaviors that interfere with the achievement of personal goals or the exercise of individual rights using the least intrusive interventions necessary and the most positively supporting interventions available.

If appropriate, people have a behavior support plan that reduces, replaces or eliminates specific behaviors. Behavior Support Plans are implemented in accordance with the DDD Behavioral Services Procedural Guidelines.

Behavior Support Plans are developed based on information gathered through a functional behavioral assessment that is completed by a qualified professional and identifies physical or environmental issues that need to be addressed to reduce, replace or eliminate the behavior. The Behavior Support Plan outlines the specific behavioral supports that may and may not be used.

All direct support staff receive training in behavioral techniques and plans prior to implementation of support(s) to people.

Data related to the effectiveness of an individual's Behavior Support Plan is reviewed periodically, but at

least quarterly, or more often as required by the individual's needs.

Prior to imposing a rights restriction, the person meets with his/her Support Team to discuss the reason for the proposed restriction, except in extreme emergency to prevent the person from harming self or others. Criteria for removing the restriction is developed and shared with the person and legally authorized representative prior to imposing the restriction.

All behavior support plans are approved by the person's Support Team. Each Behavior Support Plan with Level 2 or 3 procedures is reviewed and/or approved by the Behavior Program Review Committee, the Human Rights Committee and the person or the person's legally authorized representative in accordance with DDD PBS 02 Guidelines for Levels of Intervention.

- (a) The use of emergency or unplanned behavior interventions that are highly intrusive are in compliance with DDD PBS 02 Level 3 Procedures and are not used more than three(3) times in a six (6) month period without a Support Team meeting to determine needed changes in the person's behavior support plan.
- (b) If people require behavioral or medical supports to prevent harm to themselves or others, such supports are provided in accordance with DDD Behavioral Services Procedural Guidelines (DDD-PBS 01 05).
- (c) The use of any restraint complies with the provisions of DDD PBS 02 Level 3 Procedures and is applied only by staff with demonstrated competency for the device or procedure used.
- (d) The organization ensures that people are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.
- (e) The organization prohibits the use of corporal punishment, seclusion, noxious or aversive stimuli forced exercise, or denial of food or liquids that are part of a person's nutritionally adequate diet.
- (f) Behavior procedures considered the most restrictive comply with the Level 4 Provisions of DDD PBS 02. Requests for the use of Level 4 Procedures are sent to the Director of Psychological and Behavioral Services for the Division of Developmental Disabilities after reviews have been completed by the Behavior Program Review Committee (BPRC), Human Rights Committee (HRC) and the legally authorized representative. The Director of Psychological and Behavioral Services determines the frequency of further review.
- (g) The only exception to the above approval requirement is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding number of times it can be used.

The use of psychotropic medications for behavior support comply with provisions of DDD PBS 02 Level 3 and are authorized by a licensed physician, preferably a psychiatrist. The use of medication(s) to reduce or change behavior associated with psychiatric symptoms shall be considered a Level 3 intervention (DDD PBS 02). These medications are authorized by the person's physician and incorporated into a Behavior Support Plan and/or a Psychotropic Medication Plan.

PRN orders for psychotropic medications are administered in accordance with the Nurse Delegation Program and the Behavioral Services Procedural Guidelines.

A person's Support Team meets to assess and address behavioral and psychiatric needs when PRN medications are used as an Emergency Procedure three (3) times within a six (6) month period.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Alabama Department of Mental Health  
 --Division of Developmental Disabilities Central and Regional Offices  
 --Office of Advocacy Services

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

#### Safeguards Concerning the Use of Restrictive Interventions

The behavioral guidelines describe all of the behavioral training and intervention strategies that are approved for use in Alabama. There are four (4) levels of procedures with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. Level 2 procedures that are considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC include procedures such as: Escape Extinction, Negative Reinforcement, Positive Practice, Reparation of Property or Restitution, Response Cost Restriction of Environmental Access, Restriction of Movement inside or outside facility, Search, and Exclusionary Timeout procedures. Level 3 procedures require review by the entire BPRC and HRC prior to implementation and include: Modification of Clothing to Limit Access to Self, One to One Staffing due to behaviors, Overcorrection, Manual Restraint, Restriction of Personal Property/visitors/phone calls, Use of Psychotropic Medications, and Closed –Door Timeout. Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure. There are only four procedures listed at this level of intervention: Mechanical Restraint – Programmatic Use, Mechanical Restraint – Emergency Use, Sensory Screening, and Manual Restraints not otherwise specified in Level 3 (these would be modifications of the usual manual holds that may need to occur with a person). ALL of the restrictive procedures must be directly related to a behavioral challenge and the function being served by that behavior. There must also be training and reinforcement to assist the person in developing more appropriate behaviors to replace the one(s) that led to the restriction. Furthermore, there must be a plan for lifting the restriction that is reasonable in terms of the individual being able to achieve the criteria set. Procedures that are prohibited include: Use of aversive stimuli, such as spray mists or bitter tasting liquids contingent upon behaviors occurring, Locked-Door Timeout or Seclusion, Corporal Punishment of any kind. While there is not a section in the behavior guidelines that lists the procedures as specifically prohibited, they are not allowed by virtue of not being in the procedures listed. Some of the definitions of procedure do refer to the fact that these are not allowed when the acceptable procedures are defined.

Prior to being assigned to a person who has a BSP, each staff person who works with an individual for whom restrictive procedures are a part of their BSP must receive specific training regarding how to implement the procedure and under what circumstances they can and cannot be used. All provider direct support professionals, QDDPs, and others must receive training in the Management of Aggressive and severe Challenging Behavior as part of their orientation training as well as via annual refreshers. Professional staff must also have that kind of training. All individuals must have Person Centered Plan in which the procedures of a BSP must be included and approved by the team and the person and then

approved by the BPRC and HRC and, for the most restrictive procedures, by the DPBS. The Division of Developmental Disabilities offers training opportunities to assist service providers develop the skills related to determining the functions of behaviors being exhibited by individuals served and to connect the prevention and intervention strategies to the behavioral functions in order to increase the likelihood of successful outcomes. BSPs require renewal on an annual basis and all of the review/approval groups mentioned above must assess the new plan and determine whether to approve the revised or new plan based upon the data presented from the previous program. Finally, certification staff routinely review personnel files for all necessary and required training.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-3-26.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

In addition to the requirements in Chapter 580-3-26 (2)(a)-(3), the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Alabama Department of Mental Health  
 --Division of Developmental Disabilities Central and Regional Offices  
 --Office of Advocacy Services

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to*

WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

**The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Operating Agency, in its function of certifying providers, and in its monitoring of direct service provision and service plan implementation, will detect any unauthorized use of restrictive interventions either through records (for instance, notes in a participant's file communicating the restriction), staff comments and discussion, or participant or family feedback during direct interviews or through communication with the advocacy hotline.

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for purposes of addressing/treating behavioral challenges and/or Psychiatric Symptoms, a Psychotropic Medication Plan be developed for the purpose of ensuring that reductions are considered and implemented whenever possible, based upon presentation of data to the treating Psychiatrist/Doctor. The person's habilitation team provides documentation of behavioral data and reports of psychiatric symptoms (if applicable) at every session with the treating doctor for review. If the criteria set by the team have been met, this information is presented to the doctor and consideration is given to a reduction in medication unless contra-indicated for medical or other extenuating circumstances that should be documented. The medication plan can be a section within the person's BSP. If a person is having "spikes" in their behaviors or in psychiatric symptoms, the provider is required to attempt to determine what factors might account for those

peaks and make their findings known to the doctor. They are also required to modify the person's plan if necessary to address the factors leading to the ineffectiveness of the medications. Finally, certification staff routinely review records of individuals receiving Psychotropic Medication for all necessary monitoring and documentation including necessary lab work.

Sometimes individuals have behavioral episodes that result in visits to an ER or an admission to a hospital. This requires that notification be provided to the Regional Community Services office and the IPMS procedures are followed in those cases. If it becomes evident that there are problems with medication administration, follow-up monitoring and, sometimes, investigations are conducted as outlined in the IPMS. Finally, certification staff routinely review information related to Best Possible Health, Protection for Abuse, Neglect, Mistreatment, and Exploitation, and Safe Environments.

Medications are reviewed through the IPMS system, quarter regional and statewide QE reports, agency participation in the Nurse Delegation Program, and routine and "for-cause" certification reviews.

Provider employed or contracted nurses directly administer certain medications and delegate others to trained direct care staff. The nurse is responsible to provide periodic and regular evaluation and monitoring of the staff performing the delegated task, and to conduct quality monitoring of the tasks performed by the staff. This evaluation and monitoring must occur at least quarterly. Direct care staff must be medication assistant certified (MAC) workers in order to assist with medication administration. The delegating RN or LPN may withdraw delegation authority (of direct care staff) at any time.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Alabama Department of Mental Health:

--Division of Developmental Disabilities

Three teams of professionals, including a medical doctor, a psychiatrist and a behavior analyst are available through the Regional Offices to advise and assist with programs for reducing medications. These teams also provide education to local doctors who sometimes do not know the risk factors and alternatives to combinations of certain medications.

Monitoring by nursing staff with the Regional Offices of the Division looks for potentially harmful medication combinations among other things at least twice per year. The nursing staff is also available for technical assistance. DDD submits a compliance review on Nurse Delegation Program to the AL Board of Nursing annually.

Incident reports that include medication errors in three categories are required by IPMS and entered into an electronic database where they are tracked at the consumer and provider level, and trended at the systems level. Intervention will occur from the Regional Offices and/or from Certification as needed. The threshold for a plan of action is a rate of 0.1. Level two (2) medication error requires action follow-up by the provider and the Regional Office. Level three (3) medication error requires an investigation by the provider and the Regional Office.

Certification surveys include reviews of nursing notes and incident reports, every year or every other year, depending on the overall score achieved by the provider on the previous survey. Certification surveys also include for cause surveys and provisional status re-surveys as needed.

--Office of Advocacy Services

Advocates review consumer living situations, including issues regarding health and welfare as well as rights, and check on medication administration on a sample basis.

Alabama Medicaid Agency:

Annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews.

Annual survey of providers, including a complete record review on a sample basis.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State policy follows the nursing practice act of the State. Certain types of medication administration must be performed by a nurse, but other types, such as assisting with the delivery of prescribed oral, topical, inhalant, eye or ear medications may be delegated to a trained direct care staff under a protocol approved by the Board of Nursing.

##### iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

- (a) Specify State agency (or agencies) to which errors are reported:

Alabama Department of Mental Health:  
--Division of Developmental Disabilities

The Division of Developmental Disabilities provides ongoing reports to the Alabama Board of Nursing. Agency reports to the DDD are included in the DDD reports to the Board of Nursing annually.

- (b) Specify the types of medication errors that providers are required to *record*:

A. Medication Error a medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error.

Severities of medication errors are defined as follows:

Level 1 includes incidents in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required.

Level 2 includes incidents in which the individual experienced short term, reversible adverse consequences and treatment(s), and/or intervention(s) was/were needed in addition to monitoring and observation.

Level 3 includes incidents in which the individual experienced life-threatening and/or permanent adverse consequences.

The agency must record level 1, 2 and 3 medication errors.

- (c) Specify the types of medication errors that providers must *report* to the State:

The agency must report level 1, 2 and 3 medication errors to RCS. Levels 2 and 3 must be reported verbally within 24 hours. Levels 1 and 2 must be reported on an incident form monthly. Levels 3 must be reported on an incident report form within 72 hours. No action follow-up is required by RCS or the provider for Level 1 medication errors, but such errors are tracked and trended to determine patterns and need for possible intervention.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Alabama Department of Mental Health:  
--Division of Developmental Disabilities

Nursing staff with the Regional Offices of the Division monitor the nursing evaluation and monitoring conducted by the provider employed or contracted nurses at least twice per year. This monitoring looks for potentially harmful medication combinations among other things.

Incident reports that include medication errors in three categories are required by certification and entered into an electronic database where they are tracked at the consumer and provider level, and trended at the systems level.

Certification surveys include reviews of nursing notes and incident reports, every year or every other year, depending on the overall score achieved by the provider on the previous survey. Certification surveys also include surveys and re-surveys as needed.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

**The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.** (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

##### i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

#### Performance Measures

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

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

**Performance Measure:**

**1. Number and percent of waiver participants who received annual rights training on abuse, neglect, mistreatment, and exploitation. Percent equals the number of participants that received annual rights training divided by the number of sampled participant records.**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1. If the pop. is 30 or less, the sample will be 2 people. 2. If the pop. is 31-60, the sample will be 3 people. 3. If the pop. is more than 60 people, the sample will be 5% up to a 15 people.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**2. Number and percent of employees who received refresher training in abuse, neglect, mistreatment, and exploitation. Percent equals number of number of employees receiving refresher training divided by the number of employee records sampled.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		varies depending on the amount of information needed to validate the organization's practices. Generally, the sample size will be 10%, no less than 6 people and no more than 30 people.
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		

**Data Aggregation and Analysis:**

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

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of investigations closed within 60 days. Percent equals the number of incidents closed within 60 days divided by the number of investigations.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of restraints applied three (3) times in a six month (6) period that resulted in a team meeting. Percent equals the number of times a restraint has been applied 3 times within a six month period resulting in a team meeting divided by the number of times a restraint has been applied 3 times within a six month period.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

		<input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

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

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

**Performance Measure:**

**1. Number and percent of providers that receive a "yes" rating in each of the five (5) indicator questions under Factor Five: Best Possible Health during certification. Percent equals the number of providers reviewed that receive a "yes" rating in each of the 5 indicator questions under Factor Five divided by the number of providers reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

There are many factors tracked in the IPMS system, and reports from that system, run quarterly, are reviewed by the Regional Offices, the Director of Quality and Planning and the Quality Council. The AL Medicaid Agency is an active participant in these meetings. The intent is to seek out trends and issue guidance to the necessary parties in order to prevent problems in the future.

**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.

Overall, there is an incident report for every reportable incident, and a determination made for each what action is needed. The process is described in detail in Appendix G-1 b, c, and d. This process provides for immediate remediation of situations which may be harmful to individuals. Beyond this response, however, is a process of aggregation and analysis of information, at the regional level and statewide. The Regional Offices gather information from the IPMS system quarterly and summarize it trying to explain the findings and suggesting follow-up actions, to include additional training, sometimes requiring a plan of correction, and occasionally starting a for-cause certification review. These reports are provided to the Director of Quality and Planning, who aggregates the data from the reports and from the IPMS system, and shares and discusses these with the Quality Council and the DD Sub-committee. These committees often recommends and pursues a course of action when a trend emerges.

For example, recently a trend emerged where participants were falling at a higher rate than normal. The Council and Director of Quality and Planning gathered information on the prevention of falls and shared it with all providers, did training on preventative measures such as environmental safety checks, then tracked the incidents and saw a commensurate decline. In similar manner, issues with choking, issues with van turnovers, and issues with house fires have come into view and been addressed with targeted and effective intervention, during the last several years.

- ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

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

operational.

**No**

**Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 2)

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must

be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Appendix A Medicaid Oversight: Medicaid Agency will trend and analyze and share findings with the Administration of the Operating Agency. The quality assurance and improvement methodology employed by Medicaid staff gathers information from on-site and off-site record reviews, participant surveys, and direct observation, as well as from data forwarded from the operating agency. Weighting and trending of the multiple data elements is achieved with an algorithm designed by the University of Alabama at Birmingham to be used for all the State's HCBS Waiver Programs.

Appendix B Level of Care Evaluations: the Administration of the Operating Agency will jointly consider the findings from the performance measures and determine the necessary actions. Specifically, the Director of System Management will trend and analyze quarterly and annually; the Associate Commissioner will prioritize; and the Director of Waiver and Case Management Services and/or the Director of Quality and Planning will implement the prioritized recommendations with the support of the Directors of the Regional Community Service Offices. All system changes are shared with the Alabama Medicaid Agency prior to implementation.

Appendix C Qualified Providers and Certification: The Administration of the Operating Agency will jointly consider the findings from certification surveys and the related performance measures, and determine the necessary actions. Specifically, the Director of Quality and Planning and the Director of Certification will analyze and trend the information quarterly and annually and share this information with the Quality Council/Developmental Disabilities Sub-Coordinating Committee. This council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. Prioritized recommendations from the council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix D Service Planning: The Regional Offices of the Operating Agency will review the information from the monitoring of case management agencies and provide quarterly summaries of findings and recommendations. This information from the performance measures can be reviewed agency by agency, aggregated by region, and aggregated statewide. It can also be trended from quarter to quarter and year to year, within the same aggregation parameters. The Director of Waiver and Case Management Services will analyze and trend statewide data and also consider and prioritize the recommendations of the Regional Offices. The Associate Commissioner will approve recommendations for implementation. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix G Health and Welfare: The Regional Offices review all incident and investigation reports quarterly and provide summaries and analysis to the Director of Quality and Planning, who shares this information, as well as statewide trends, with the Quality Council. Prioritized recommendations from this council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes in the rule must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix I Fiscal Accountability: The Alabama Medicaid Agency will, through its monitoring process,

discover problems and resolve them. The Medicaid Agency will also see, through trending of these monitoring reports, any areas of concern which may need to be addressed through efforts ranging from training to policy and regulation to changes in the MMIS edits and audits.

In conjunction with the Director of Quality and Planning, the Director of Systems Management will provide quarterly summaries and analysis of waiver discovery and remediation indicators. Quality Improvement Strategy data for Health and Welfare, as well as Level of Care, Qualified Providers, Service Planning, and Self-Directed Services will be presented during the same Quality Council/Developmental Disabilities Sub-Coordinating Committee meeting. This Quality Council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. If recommendations are made they will be prioritized and reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. Evaluation of the QIS plan is on-going as data is presented quarterly. The QIS will be updated to track discovery and remediation data as program requirements change. At a minimum, the QIS plan will be reviewed upon CMS three year assurances review and updated upon renewal. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

**ii. System Improvement Activities**

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

**b. System Design Changes**

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

All system design changes have a component of evaluation built into the plan before the design change is implemented. For example, the Division implemented a new set of regulatory standards October 1, 2012. The Division contracted with the Council on Quality and Leadership (CQL) to align our requirements with their Basic Assurances(c). The change required extensive and ongoing training of community services providers. It included ongoing reports and evaluations by the Department of Mental Health, Division of Developmental Disabilities Certification Staff with community providers. Finally, training was provided by CQL to certification staff and has been validated annually.

The current direction of system design change is multifaceted. First, beginning October 1, 2014, the provider organizations will be required to develop and implement an ongoing quality enhancement plan or Basic Assurances System. Providers will complete an organizational assessment of their compliance with the Basic Assurances. Based on the assessment, they will have to identify priority areas to target for improvement for each factor and/or develop monitoring systems to ensure maintenance of compliance. Second, Divisional Quality Enhancement Staff have entered into a training with CQL to become certified quality analysts. In this role, they have analyzed the first year of certification data and are developing focused trainings on specific areas both regionally and statewide to provide assistance to community organizations. Third, Divisional QE staff and other certified trainers are required to provide three (3) 4-day workshops in Personal Outcome Measures Training(c) as developed by CQL. The vision is for all waiver participants to participate in an outcome interview to determine preference, the presence or absence of outcomes and supports, and the

priorities for attainment, which will become the foundation of the individuals' person centered plans. This is how the Division envisions more effective person centered planning in order to meet the new CMS Regulations regarding Home and Community Based Services.

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

The Division will continue to provide monitoring, technical assistance and validity and reliability checks to all stakeholder including division staff regarding the above processes through administrative review and contract services with CQL. These activities support the assurance measurements noted earlier while moving the state toward compliance with CMS final rule regarding HCBS. Among the operations that are subject to the planning and evaluation of the stakeholders, are all the various functions that together make up the quality improvement strategy. These would include, for example, how plans of care are developed and how well case management is functioning; how well our providers score on certification and what is the real level of satisfaction of participants, relative to those certification scores; how are incidents addressed in order to prevent as many adverse consequences as possible.

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

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

The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:

- The Alabama Medicaid Agency serves as the administering agency for this Waiver Program. The operating agency is the Alabama Department of Mental Health/Division of Developmental Disabilities. The Provider Audit Unit of the Medicaid Agency monitors the payments made to providers of waiver services annually. The Medicaid Agency and the Department of Mental Health are both audited externally by the Alabama Department of Examiners of Public Accounts on an annual basis.
- The Fiscal Agent Liaison Division/Contract Monitoring Unit of the Alabama Medicaid Agency monitors the processing and payment of Medicaid claims through the Medicaid Management Information Systems (MMIS). Periodic reviews and targeted reviews of claims are performed when potential system errors are identified. The Medicaid Management Information Systems performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.
- The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.
- The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

## Appendix I: Financial Accountability

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### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")***

**i. Sub-Assurances:**

- a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.***

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

**2. The number and percent of claims where case management documentation does not verify service delivery. Percent equals the number of sampled participant records in which at least one service was not verified by case management records, divided by the number of participant records in the sample.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 5%
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**1. The number and percent of claims paid for services not included in the approved service plan. Percent equals the number of participant records sampled which show one or more claims paid which were not in the approved service plan, divided by the total number of participant records in the sample.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 5%

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

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

**Performance Measures**

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

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

- 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 plan of care, 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)**

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

**c. Timelines**

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

- No**
- Yes**

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

**Appendix I: Financial Accountability**

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

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

The Alabama Medicaid Agency is responsible for establishing provider payment rates for waiver services. Payment made by Medicaid to LAH waiver providers are on a fee-for-service basis and are based upon a number of factors:

- Current pricing for similar services
- State-to-State comparisons
- Geographical comparisons within the state
- Comparisons of different payers for similar services

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

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Each waiver participant, once approved, is added to the Alabama Medicaid's Recipient Level of Care Panel. This file holds approved dates of eligibility for waiver services.

Provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. This system, known as ADIDIS, checks claims against prior authorizations to ensure the services billed are approved by the operating agency's review of the plan of care. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through Hewlett Packard (HP), the Fiscal Intermediary as follows:

- Payments made by Medicaid to providers are on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.
- For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months.
- If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.
- Payment is based on the number of units of service reported on the claim for each procedure code.
- Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.
- All claims must be filed within twelve months from the date of service.
- Payment is based on the number of units of service reported on the claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from the point of service through billing and reimbursement. Discrepancies are initially handled at the local level.
- The LAH Waiver administrator monitors expenditures on a bi-annual basis or as often as needed and monitors problems with particular service providers. If costs appear to be out of line or unusual, the provider is contacted and follow-up action is implemented as needed.

## Appendix I: Financial Accountability

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

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

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

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the systems reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State –determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by HP personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check write schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (*select one*):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

State DMH/DDD (Alabama Department of Mental Health/Division of Developmental Disabilities) is the operating agency for the LAH waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

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

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State**

recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

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

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

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

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

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

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

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

Providers may reassign payments only to DMH, the operating agency for the LAH waiver.

ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial

accountability is assured when an OHCDS arrangement is used:

The DMH, the various Local Authorities established under Act 310, and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish but in this case they must also contract with the DMH in order for the DMH to pay the state match for them. Free choice of providers is assured by the policies and procedures in effect and practices carried out by case managers. All providers are certified and monitored between certification surveys. All subcontractors are submitted to the state for review of applicable provisions. Payments are fee-for-service through an approved MMIS system.

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of waiver payments is transferred to the Alabama Medicaid Agency by the Alabama Department of Mental Health(DMH). This is managed through an IGT process in which the Medicaid Agency determines, during each billing cycle, how much non-federal match is needed to reimburse adjudicated claims, and invoices DMH, whereupon DMH transfers these funds to the Medicaid Agency.

For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the Department of Mental Health, as of fiscal year 2009, is 100% appropriated by the legislature to the DMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust Fund.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: **Do not complete this item.**

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

---

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

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- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**
  - ii. Participants Subject to Co-pay Charges for Waiver Services.**

---

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.**
  - iii. Amount of Co-Pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.**
  - iv. Cumulative Maximum Charges.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13054.35	3160.00	16214.35	166168.00	2000.00	168168.00	151953.65
2	12888.90	2950.00	15838.90	171153.00	2085.00	173238.00	157399.10
3	12888.90	2776.00	15664.90	176288.00	2170.00	178458.00	162793.10
4	12888.90	2578.00	15466.90	181576.00	2256.00	183832.00	168365.10
5	12888.90	2396.00	15284.90	185683.00	2341.00	188024.00	172739.10

## Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	569	569	
Year 2	569	569	
Year 3	569	569	

Year 4	569	569
Year 5	569	569

## Appendix J: Cost Neutrality Demonstration

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

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The projections of utilization in this renewal reflect no increases in capacity (slots) in each year of the renewal.

Average length of stay is derived by dividing the total number of days in a waiver year by the total number of clients served. For this waiver renewal the estimated client attrition is 60 per year (estimated 6 months ALOS). In addition, during the years of this renewal, we project adding 70 individuals per year (estimated 6 months ALOS). Thus, the population of this waiver will remain the same in each year, until we are able to increase it due to the addition of funding. Our calculation of average length of stay for each year is as follows:

Participants starting year = a  
 Participants added during year = b  
 Participants leaving waiver during year = c  
 Participants to carry to next year = a - c + b  
 Total Participants served during year (Factor C) = a + b = d

$$\text{ALOS} = ((a - c) * 365 \text{ days}) + ((c + b) * 182.5 \text{ days}) / d$$

For Fiscal Year 2016 (first year of this renewal) and the remaining waiver years we have calculated an ALOS of 321 days.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is based on data collected from the electronic information system designed for this waiver. The data from FY 2011 through FY 2015 was trended forward for the waiver years of this renewal.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The electronic information system matches the 372 for unduplicated clients and for costs per user. The D' factor from the 372 reports from FY 2011 to FY 2013 was trended forward for the years of this renewal.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G for this renewal uses the projections approved in the recent renewal of Alabama's HCB Waiver for Persons with Intellectual Disabilities, Waiver #0001.R07.00, trended forward one extra year. These numbers are used again as the Living at Home Waiver and Waiver #001 serve the same population and measure cost effectiveness against the same institutional costs for the same periods of time (10/1 of any given year through 9/30 of the following year). The extra year (2020) was trended because the Living at Home Waiver's renewal cycle lags behind that of Waiver #0001 by exactly one year.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of

these estimates is as follows:

Factor G' for this renewal uses the projections approved in the recent renewal of Alabama's HCB Waiver for Persons with Intellectual Disabilities, Waiver #0001.R07.00, trended forward one extra year. These numbers are used again as the Living at Home Waiver and Waiver #001 serve the same population and measure cost effectiveness against the same institutional costs for the same periods of time (10/1 of any given year through 9/30 of the following year). The extra year (2020) was trended because the Living at Home Waiver's renewal cycle lags behind that of Waiver #0001 by exactly one year.

**Appendix J: Cost Neutrality Demonstration**

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

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

Waiver Services
Day Habilitation
Employment Support
Personal Care
Prevocational Services
Respite
Benefits and Career Counseling
Community Experience
Community Specialist Services
Crisis Intervention
Environmental Accessibility Adaptations
Housing Stabilization Service
Individual Directed Goods and Services
Occupational Therapy
Personal Emergency Response System
Physical Therapy
Positive Behavior Support
Residential Habilitation Other Living Arrangement (OLA)
Skilled Nursing
Specialized Medical Equipment
Specialized Medical Supplies
Speech and Language Therapy
Supported Employment Emergency Transportation

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

## Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						4696357.57
Day Habilitation Level 3	15 minutes	48	3858.00	3.53	653699.52	
Day Habilitation Level 2	15 minutes	107	3729.00	2.74	1093268.22	
Day Habilitation Level 3 w Transport	15 minutes	31	3468.00	3.84	412830.72	
Day Habilitation Level 4 w Transport	15 minutes	5	2947.00	4.85	71464.75	
Day Habilitation Level 1 w Transport	15 minutes	67	3568.00	2.26	540266.56	
Day Habilitation Level 1	15 minutes	112	4510.00	1.94	979932.80	
Day Habilitation Level 4	15 minutes	5	2960.00	4.53	67044.00	
Day Habilitation Level 2 w Transport	15 minutes	78	3690.00	3.05	877851.00	
<b>Employment Support Total:</b>						239782.40
Supported Employment Small Group 15 minute	15 minutes	20	3018.00	3.84	231782.40	
Individual Job Developer	15 minutes	2	320.00	10.00	6400.00	
Individual Job Coach	15 minutes	2	160.00	5.00	1600.00	
<b>Personal Care Total:</b>						1700567.82
Self-Directed Personal Care	15 minutes	12	2427.00	3.48	101351.52	
Personal Care on Worksite	15 minutes	10	107.00	4.35	4654.50	
Personal Care Transportation	mile	42	1495.00	0.52	32650.80	
Personal Care	15 minutes	145	2762.00	3.90	1561911.00	
<b>Prevocational Services Total:</b>						77592.00
Prevocational Services	hour	8	795.00	12.20	77592.00	
<b>Respite Total:</b>						160433.52
Respite In Home	15 minutes	8	2561.00	3.12	63922.56	
Respite Out of Home	15 minutes	21	1473.00	3.12	96510.96	
<b>Benefits and Career Counseling Total:</b>						1200.00
Benefits and Career Counseling	15 minutes	3	40.00	10.00	1200.00	
<b>Community Experience Total:</b>						220602.20
Community Experience 1:1	15 minutes	5	868.00	16.80	72912.00	
Community Experience Small Group	15 minutes	10	868.00	13.46	116832.80	
Community Experience Self-Directed	15 minutes	3	868.00	11.85	30857.40	

<b>Community Specialist Services Total:</b>						1291.68
Community Specialist Services	15 minutes	3	18.00	11.96	645.84	
Community Specialist Services Self-Directed	15 minutes	3	18.00	11.96	645.84	
<b>Crisis Intervention Total:</b>						9097.92
Crisis Intervention	15 minutes	3	324.00	9.36	9097.92	
<b>Environmental Accessibility Adaptations Total:</b>						19968.00
Environmental Accessibility Adaptations	item	2	1.00	4992.00	9984.00	
Environmental Accessibility Adaptations Self-Directed	item	2	1.00	4992.00	9984.00	
<b>Housing Stabilization Service Total:</b>						1618.20
Housing Stabilization Service	15 minutes	4	29.00	13.95	1618.20	
<b>Individual Directed Goods and Services Total:</b>						10000.00
Individual Directed Goods and Services	item	10	1.00	1000.00	10000.00	
<b>Occupational Therapy Total:</b>						17160.00
Occupational Therapy	15 minutes	5	120.00	14.30	8580.00	
Occupational Therapy Self-Directed	15 minutes	5	120.00	14.30	8580.00	
<b>Personal Emergency Response System Total:</b>						30000.00
Personal Emergency Response System	item	5	1.00	3000.00	15000.00	
Personal Emergency Response System Self-Directed	item	5	1.00	3000.00	15000.00	
<b>Physical Therapy Total:</b>						24538.80
Physical Therapy	15 minutes	3	286.00	14.30	12269.40	
Physical Therapy Self-Directed	15 minutes	3	286.00	14.30	12269.40	
<b>Positive Behavior Support Total:</b>						10510.50
Positive Behavior Support Level 1 Prof Certified	15 minutes	2	75.00	19.50	2925.00	
Positive Behavior Support Level 2 Professional	15 minutes	2	75.00	19.50	2925.00	
Positive Behavior Support Level 3 Technician	15 minutes	2	32.00	14.30	915.20	
Positive Behavior Supports Level 1 Prof Certified Self-Directed	15 minutes	2	145.00	9.10	2639.00	
Positive Behavior Supports Level 2 Professional Self-Directed	15 minutes	1	45.00	19.50	877.50	
Positive Behavior Supports Level 3 Technician Self-Directed	15 minutes	1	16.00	14.30	228.80	
<b>Residential Habilitation Other Living Arrangement (OLA) Total:</b>						21888.00
Residential Habilitation						

(Other Living Arrangement)	15 minutes	4	1200.00	4.56	21888.00	
<b>Skilled Nursing Total:</b>						37148.80
RN Nursing	hour	4	62.00	36.40	9027.20	
LPN Nursing	hour	4	62.00	36.40	9027.20	
Self-Directed RN Nursing	hour	3	250.00	20.80	15600.00	
Self-Directed LPN Nursing	hour	2	48.00	36.40	3494.40	
<b>Specialized Medical Equipment Total:</b>						1485.88
Specialized Medical Equipment	item	2	1.00	371.47	742.94	
Specialized Medical Equipment Self-Directed	item	2	1.00	371.47	742.94	
<b>Specialized Medical Supplies Total:</b>						122598.00
Specialized Medical Supplies	item	49	9.00	139.00	61299.00	
Specialized Medical Supplies Self-Directed	item	49	9.00	139.00	61299.00	
<b>Speech and Language Therapy Total:</b>						4084.08
Speech and Language Therapy	encounter	2	17.00	60.06	2042.04	
Speech and Language Therapy Self-Directed	encounter	2	17.00	60.06	2042.04	
<b>Supported Employment Emergency Transportation Total:</b>						19999.20
Supported Employment Emergency Transportation mile	mile	10	1923.00	0.52	9999.60	
Supported Employment Emergency Transportation item	mile	10	1923.00	0.52	9999.60	
<b>GRAND TOTAL:</b>					7427924.57	
Total Estimated Unduplicated Participants:					569	
Factor D (Divide total by number of participants):					13054.35	
Average Length of Stay on the Waiver:						348

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						4696357.57

Day Habilitation Level 3	15 minutes	48	3858.00	3.53	653699.52	
Day Habilitation Level 2	15 minutes	107	3729.00	2.74	1093268.22	
Day Habilitation Level 3 w Transport	15 minutes	31	3468.00	3.84	412830.72	
Day Habilitation Level 4 w Transport	15 minutes	5	2947.00	4.85	71464.75	
Day Habilitation Level 1 w Transport	15 minutes	67	3568.00	2.26	540266.56	
Day Habilitation Level 1	15 minutes	112	4510.00	1.94	979932.80	
Day Habilitation Level 4	15 minutes	5	2960.00	4.53	67044.00	
Day Habilitation Level 2 w Transport	15 minutes	78	3690.00	3.05	877851.00	
<b>Employment Support Total:</b>						239782.40
Supported Employment Small Group 15 minute	15 minutes	20	3018.00	3.84	231782.40	
Individual Job Developer	15 minutes	2	320.00	10.00	6400.00	
Individual Job Coach	15 minutes	2	160.00	5.00	1600.00	
<b>Personal Care Total:</b>						1700567.82
Self-Directed Personal Care	15 minutes	12	2427.00	3.48	101351.52	
Personal Care on Worksite	15 minutes	10	107.00	4.35	4654.50	
Personal Care Transportation	mile	42	1495.00	0.52	32650.80	
Personal Care	15 minutes	145	2762.00	3.90	1561911.00	
<b>Prevocational Services Total:</b>						77592.00
Prevocational Services	hour	8	795.00	12.20	77592.00	
<b>Respite Total:</b>						160433.52
Respite In Home	15 minutes	8	2561.00	3.12	63922.56	
Respite Out of Home	15 minutes	21	1473.00	3.12	96510.96	
<b>Benefits and Career Counseling Total:</b>						1200.00
Benefits and Career Counseling	15 minutes	3	40.00	10.00	1200.00	
<b>Community Experience Total:</b>						220602.20
Community Experience 1:1	15 minutes	5	868.00	16.80	72912.00	
Community Experience Small Group	15 minutes	10	868.00	13.46	116832.80	
Community Experience Self-Directed	15 minutes	3	868.00	11.85	30857.40	
<b>Community Specialist Services Total:</b>						1293.84
Community Specialist Services	15 minutes	3	18.00	11.96	645.84	
Community Specialist Services Self-Directed	15 minutes	2	18.00	18.00	648.00	

<b>Crisis Intervention Total:</b>						9097.92
Crisis Intervention	15 minutes	3	324.00	9.36	9097.92	
<b>Environmental Accessibility Adaptations Total:</b>						19968.00
Environmental Accessibility Adaptations	item	2	1.00	4992.00	9984.00	
Environmental Accessibility Adaptations Self-Directed	item	2	1.00	4992.00	9984.00	
<b>Housing Stabilization Service Total:</b>						1618.20
Housing Stabilization Service	15 minutes	4	29.00	13.95	1618.20	
<b>Individual Directed Goods and Services Total:</b>						10000.00
Individual Directed Goods and Services	item	10	1.00	1000.00	10000.00	
<b>Occupational Therapy Total:</b>						12012.00
Occupational Therapy	15 minutes	5	120.00	14.30	8580.00	
Occupational Therapy Self-Directed	15 minutes	2	120.00	14.30	3432.00	
<b>Personal Emergency Response System Total:</b>						21000.00
Personal Emergency Response System	item	5	1.00	3000.00	15000.00	
Personal Emergency Response System Self-Directed	item	2	1.00	3000.00	6000.00	
<b>Physical Therapy Total:</b>						16273.40
Physical Therapy	15 minutes	3	286.00	14.30	12269.40	
Physical Therapy Self-Directed	15 minutes	1	280.00	14.30	4004.00	
<b>Positive Behavior Support Total:</b>						8905.00
Positive Behavior Support Level 1 Prof Certified	15 minutes	2	75.00	19.50	2925.00	
Positive Behavior Support Level 2 Professional	15 minutes	2	32.00	14.30	915.20	
Positive Behavior Support Level 3 Technician	15 minutes	2	145.00	9.10	2639.00	
Positive Behavior Supports Level 1 Prof Certified Self-Directed	15 minutes	1	45.00	19.50	877.50	
Positive Behavior Supports Level 2 Professional Self-Directed	15 minutes	1	16.00	14.30	228.80	
Positive Behavior Supports Level 3 Technician Self-Directed	15 minutes	1	145.00	9.10	1319.50	
<b>Residential Habilitation Other Living Arrangement (OLA) Total:</b>						21888.00
Residential Habilitation (Other Living Arrangement)	15 minutes	4	1200.00	4.56	21888.00	
<b>Skilled Nursing Total:</b>						29057.60
RN Nursing	hour	4	62.00	36.40	9027.20	

LPN Nursing	hour	3	250.00	20.80	15600.00	
Self-Directed RN Nursing	hour	2	48.00	36.40	3494.40	
Self-Directed LPN Nursing	hour	1	45.00	20.80	936.00	
<b>Specialized Medical Equipment Total:</b>						1492.94
Specialized Medical Equipment	item	2	1.00	371.47	742.94	
Specialized Medical Equipment Self-Directed	item	2	1.00	375.00	750.00	
<b>Specialized Medical Supplies Total:</b>						63999.00
Specialized Medical Supplies	item	49	9.00	139.00	61299.00	
Specialized Medical Supplies Self-Directed	item	2	9.00	150.00	2700.00	
<b>Speech and Language Therapy Total:</b>						5645.64
Speech and Language Therapy	encounter	2	17.00	60.06	2042.04	
Speech and Language Therapy Self-Directed	encounter	1	60.00	60.06	3603.60	
<b>Supported Employment Emergency Transportation Total:</b>						14999.60
Supported Employment Emergency Transportation mile	mile	10	1923.00	0.52	9999.60	
Supported Employment Emergency Transportation item	item	5	10.00	100.00	5000.00	
<b>GRAND TOTAL:</b>					7333786.65	
Total Estimated Unduplicated Participants:					569	
Factor D (Divide total by number of participants):					12888.90	
Average Length of Stay on the Waiver:						348

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						4696357.57
Day Habilitation Level 3	15 minutes	48	3858.00	3.53	653699.52	
Day Habilitation Level 2	15 minutes	107	3729.00	2.74	1093268.22	
Day Habilitation Level 3 w Transport	15 minutes	31	3468.00	3.84	412830.72	
Day Habilitation Level 4 w						

Transport	15 minutes	5	2947.00	4.85	71464.75	
Day Habilitation Level 1 w Transport	15 minutes	67	3568.00	2.26	540266.56	
Day Habilitation Level 1	15 minutes	112	4510.00	1.94	979932.80	
Day Habilitation Level 4	15 minutes	5	2960.00	4.53	67044.00	
Day Habilitation Level 2 w Transport	15 minutes	78	3690.00	3.05	877851.00	
<b>Employment Support Total:</b>						239782.40
Supported Employment Small Group 15 minute	15 minutes	20	3018.00	3.84	231782.40	
Individual Job Developer	15 minutes	2	320.00	10.00	6400.00	
Individual Job Coach	15 minutes	2	160.00	5.00	1600.00	
<b>Personal Care Total:</b>						1700567.82
Self-Directed Personal Care	15 minutes	12	2427.00	3.48	101351.52	
Personal Care on Worksite	15 minutes	10	107.00	4.35	4654.50	
Personal Care Transportation	mile	42	1495.00	0.52	32650.80	
Personal Care	15 minutes	145	2762.00	3.90	1561911.00	
<b>Prevocational Services Total:</b>						77592.00
Prevocational Services	hour	8	795.00	12.20	77592.00	
<b>Respite Total:</b>						160433.52
Respite In Home	15 minutes	8	2561.00	3.12	63922.56	
Respite Out of Home	15 minutes	21	1473.00	3.12	96510.96	
<b>Benefits and Career Counseling Total:</b>						1200.00
Benefits and Career Counseling	15 minutes	3	40.00	10.00	1200.00	
<b>Community Experience Total:</b>						220602.20
Community Experience 1:1	15 minutes	5	868.00	16.80	72912.00	
Community Experience Small Group	15 minutes	10	868.00	13.46	116832.80	
Community Experience Self-Directed	15 minutes	3	868.00	11.85	30857.40	
<b>Community Specialist Services Total:</b>						1293.84
Community Specialist Services	15 minutes	3	18.00	11.96	645.84	
Community Specialist Services Self-Directed	15 minutes	2	18.00	18.00	648.00	
<b>Crisis Intervention Total:</b>						9097.92
Crisis Intervention	15 minutes	3	324.00	9.36	9097.92	
<b>Environmental Accessibility Adaptations Total:</b>						19968.00

Environmental Accessibility Adaptations	item	2	1.00	4992.00	9984.00	
Environmental Accessibility Adaptations Self-Directed	item	2	1.00	4992.00	9984.00	
<b>Housing Stabilization Service Total:</b>						1618.20
Housing Stabilization Service	15 minutes	4	29.00	13.95	1618.20	
<b>Individual Directed Goods and Services Total:</b>						10000.00
Individual Directed Goods and Services	item	10	1.00	1000.00	10000.00	
<b>Occupational Therapy Total:</b>						12012.00
Occupational Therapy	15 minutes	5	120.00	14.30	8580.00	
Occupational Therapy Self-Directed	15 minutes	2	120.00	14.30	3432.00	
<b>Personal Emergency Response System Total:</b>						21000.00
Personal Emergency Response System	item	5	1.00	3000.00	15000.00	
Personal Emergency Response System Self-Directed	item	2	1.00	3000.00	6000.00	
<b>Physical Therapy Total:</b>						16273.40
Physical Therapy	15 minutes	3	286.00	14.30	12269.40	
Physical Therapy Self-Directed	15 minutes	1	280.00	14.30	4004.00	
<b>Positive Behavior Support Total:</b>						8905.00
Positive Behavior Support Level 1 Prof Certified	15 minutes	2	75.00	19.50	2925.00	
Positive Behavior Support Level 2 Professional	15 minutes	2	32.00	14.30	915.20	
Positive Behavior Support Level 3 Technician	15 minutes	2	145.00	9.10	2639.00	
Positive Behavior Supports Level 1 Prof Certified Self-Directed	15 minutes	1	45.00	19.50	877.50	
Positive Behavior Supports Level 2 Professional Self-Directed	15 minutes	1	16.00	14.30	228.80	
Positive Behavior Supports Level 3 Technician Self-Directed	15 minutes	1	145.00	9.10	1319.50	
<b>Residential Habilitation Other Living Arrangement (OLA) Total:</b>						21888.00
Residential Habilitation (Other Living Arrangement)	15 minutes	4	1200.00	4.56	21888.00	
<b>Skilled Nursing Total:</b>						29057.60
RN Nursing	hour	4	62.00	36.40	9027.20	
LPN Nursing	hour	3	250.00	20.80	15600.00	
Self-Directed RN Nursing	hour	2	48.00	36.40	3494.40	
Self-Directed LPN Nursing	hour	1	45.00	20.80	936.00	
<b>Specialized Medical</b>						

<b>Equipment Total:</b>						1492.94
Specialized Medical Equipment	item	2	1.00	371.47	742.94	
Specialized Medical Equipment Self-Directed	item	2	1.00	375.00	750.00	
<b>Specialized Medical Supplies Total:</b>						63999.00
Specialized Medical Supplies	item	49	9.00	139.00	61299.00	
Specialized Medical Supplies Self-Directed	item	2	9.00	150.00	2700.00	
<b>Speech and Language Therapy Total:</b>						5645.64
Speech and Language Therapy	encounter	2	17.00	60.06	2042.04	
Speech and Language Therapy Self-Directed	encounter	1	60.00	60.06	3603.60	
<b>Supported Employment Emergency Transportation Total:</b>						14999.60
Supported Employment Emergency Transportation mile	mile	10	1923.00	0.52	9999.60	
Supported Employment Emergency Transportation item	item	5	10.00	100.00	5000.00	
<b>GRAND TOTAL:</b>						7333786.65
Total Estimated Unduplicated Participants:						569
Factor D (Divide total by number of participants):						12888.90
Average Length of Stay on the Waiver:						348

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						4696357.57
Day Habilitation Level 3	15 minutes	48	3858.00	3.53	653699.52	
Day Habilitation Level 2	15 minutes	107	3729.00	2.74	1093268.22	
Day Habilitation Level 3 w Transport	15 minutes	31	3468.00	3.84	412830.72	
Day Habilitation Level 4 w Transport	15 minutes	5	2947.00	4.85	71464.75	
Day Habilitation Level 1 w Transport	15 minutes	67	3568.00	2.26	540266.56	
Day Habilitation Level 1	15 minutes	112	4510.00	1.94	979932.80	

Day Habilitation Level 4	15 minutes	5	2960.00	4.53	67044.00	
Day Habilitation Level 2 w Transport	15 minutes	78	3690.00	3.05	877851.00	
<b>Employment Support Total:</b>						239782.40
Supported Employment Small Group 15 minute	15 minutes	20	3018.00	3.84	231782.40	
Individual Job Developer	15 minutes	2	320.00	10.00	6400.00	
Individual Job Coach	15 minutes	2	160.00	5.00	1600.00	
<b>Personal Care Total:</b>						1700567.82
Self-Directed Personal Care	15 minutes	12	2427.00	3.48	101351.52	
Personal Care on Worksite	15 minutes	10	107.00	4.35	4654.50	
Personal Care Transportation	mile	42	1495.00	0.52	32650.80	
Personal Care	15 minutes	145	2762.00	3.90	1561911.00	
<b>Prevocational Services Total:</b>						77592.00
Prevocational Services	hour	8	795.00	12.20	77592.00	
<b>Respite Total:</b>						160433.52
Respite In Home	15 minutes	8	2561.00	3.12	63922.56	
Respite Out of Home	15 minutes	21	1473.00	3.12	96510.96	
<b>Benefits and Career Counseling Total:</b>						1200.00
Benefits and Career Counseling	15 minutes	3	40.00	10.00	1200.00	
<b>Community Experience Total:</b>						220602.20
Community Experience 1:1	15 minutes	5	868.00	16.80	72912.00	
Community Experience Small Group	15 minutes	10	868.00	13.46	116832.80	
Community Experience Self-Directed	15 minutes	3	868.00	11.85	30857.40	
<b>Community Specialist Services Total:</b>						1293.84
Community Specialist Services	15 minutes	3	18.00	11.96	645.84	
Community Specialist Services Self-Directed	15 minutes	2	18.00	18.00	648.00	
<b>Crisis Intervention Total:</b>						9097.92
Crisis Intervention	15 minutes	3	324.00	9.36	9097.92	
<b>Environmental Accessibility Adaptations Total:</b>						19968.00
Environmental Accessibility Adaptations	item	2	1.00	4992.00	9984.00	
Environmental Accessibility Adaptations Self-Directed	item	2	1.00	4992.00	9984.00	
<b>Housing Stabilization Service Total:</b>						1618.20

Housing Stabilization Service	15 minutes	4	29.00	13.95	1618.20	
<b>Individual Directed Goods and Services Total:</b>						10000.00
Individual Directed Goods and Services	item	10	1.00	1000.00	10000.00	
<b>Occupational Therapy Total:</b>						12012.00
Occupational Therapy	15 minutes	5	120.00	14.30	8580.00	
Occupational Therapy Self-Directed	15 minutes	2	120.00	14.30	3432.00	
<b>Personal Emergency Response System Total:</b>						21000.00
Personal Emergency Response System	item	5	1.00	3000.00	15000.00	
Personal Emergency Response System Self-Directed	item	2	1.00	3000.00	6000.00	
<b>Physical Therapy Total:</b>						16273.40
Physical Therapy	15 minutes	3	286.00	14.30	12269.40	
Physical Therapy Self-Directed	15 minutes	1	280.00	14.30	4004.00	
<b>Positive Behavior Support Total:</b>						8905.00
Positive Behavior Support Level 1 Prof Certified	15 minutes	2	75.00	19.50	2925.00	
Positive Behavior Support Level 2 Professional	15 minutes	2	32.00	14.30	915.20	
Positive Behavior Support Level 3 Technician	15 minutes	2	145.00	9.10	2639.00	
Positive Behavior Supports Level 1 Prof Certified Self-Directed	15 minutes	1	45.00	19.50	877.50	
Positive Behavior Supports Level 2 Professional Self-Directed	15 minutes	1	16.00	14.30	228.80	
Positive Behavior Supports Level 3 Technician Self-Directed	15 minutes	1	145.00	9.10	1319.50	
<b>Residential Habilitation Other Living Arrangement (OLA) Total:</b>						21888.00
Residential Habilitation (Other Living Arrangement)	15 minutes	4	1200.00	4.56	21888.00	
<b>Skilled Nursing Total:</b>						29057.60
RN Nursing	hour	4	62.00	36.40	9027.20	
LPN Nursing	hour	3	250.00	20.80	15600.00	
Self-Directed RN Nursing	hour	2	48.00	36.40	3494.40	
Self-Directed LPN Nursing	hour	1	45.00	20.80	936.00	
<b>Specialized Medical Equipment Total:</b>						1492.94
Specialized Medical Equipment	item	2	1.00	371.47	742.94	
Specialized Medical Equipment Self-Directed	item	2	1.00	375.00	750.00	
<b>Specialized Medical Supplies</b>						

<b>Total:</b>						<b>63999.00</b>
Specialized Medical Supplies	item	49	9.00	139.00	61299.00	
Specialized Medical Supplies Self-Directed	item	2	9.00	150.00	2700.00	
<b>Speech and Language Therapy Total:</b>						<b>5645.64</b>
Speech and Language Therapy	encounter	2	17.00	60.06	2042.04	
Speech and Language Therapy Self-Directed	encounter	1	60.00	60.06	3603.60	
<b>Supported Employment Emergency Transportation Total:</b>						<b>14999.60</b>
Supported Employment Emergency Transportation mile	mile	10	1923.00	0.52	9999.60	
Supported Employment Emergency Transportation item	item	5	10.00	100.00	5000.00	
<b>GRAND TOTAL:</b>						<b>7333786.65</b>
Total Estimated Unduplicated Participants:						<b>569</b>
Factor D (Divide total by number of participants):						<b>12888.90</b>
Average Length of Stay on the Waiver:						<b>348</b>

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						<b>4696357.57</b>
Day Habilitation Level 3	15 minutes	48	3858.00	3.53	653699.52	
Day Habilitation Level 2	15 minutes	107	3729.00	2.74	1093268.22	
Day Habilitation Level 3 w Transport	15 minutes	31	3468.00	3.84	412830.72	
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Day Habilitation Level 1	15 minutes	112	4510.00	1.94	979932.80	
Day Habilitation Level 4	15 minutes	5	2960.00	4.53	67044.00	
Day Habilitation Level 2 w Transport	15 minutes	78	3690.00	3.05	877851.00	
<b>Employment Support Total:</b>						<b>239782.40</b>
Supported Employment						

Small Group 15 minute	15 minutes	20	3018.00	3.84	231782.40	
Individual Job Developer	15 minutes	2	320.00	10.00	6400.00	
Individual Job Coach	15 minutes	2	160.00	5.00	1600.00	
<b>Personal Care Total:</b>						1700567.82
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Personal Care on Worksite	15 minutes	10	107.00	4.35	4654.50	
Personal Care Transportation	mile	42	1495.00	0.52	32650.80	
Personal Care	15 minutes	145	2762.00	3.90	1561911.00	
<b>Prevocational Services Total:</b>						77592.00
Prevocational Services	hour	8	795.00	12.20	77592.00	
<b>Respite Total:</b>						160433.52
Respite In Home	15 minutes	8	2561.00	3.12	63922.56	
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<b>Benefits and Career Counseling Total:</b>						1200.00
Benefits and Career Counseling	15 minutes	3	40.00	10.00	1200.00	
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Community Experience 1:1	15 minutes	5	868.00	16.80	72912.00	
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<b>Community Specialist Services Total:</b>						1293.84
Community Specialist Services	15 minutes	3	18.00	11.96	645.84	
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Crisis Intervention	15 minutes	3	324.00	9.36	9097.92	
<b>Environmental Accessibility Adaptations Total:</b>						19968.00
Environmental Accessibility Adaptations	item	2	1.00	4992.00	9984.00	
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<b>Occupational Therapy Total:</b>						12012.00
Occupational Therapy	15 minutes	5	120.00	14.30	8580.00	
Occupational Therapy Self-Directed	15 minutes	2	120.00	14.30	3432.00	
<b>Personal Emergency Response System Total:</b>						21000.00
Personal Emergency Response System	item	5	1.00	3000.00	15000.00	
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Specialized Medical Supplies	item	49	9.00	139.00	61299.00	
Specialized Medical Supplies Self-Directed	item	2	9.00	150.00	2700.00	
<b>Speech and Language</b>						

<b>Therapy Total:</b>						5645.64
Speech and Language Therapy	encounter	2	17.00	60.06	2042.04	
Speech and Language Therapy Self-Directed	encounter	1	60.00	60.06	3603.60	
<b>Supported Employment Emergency Transportation Total:</b>						14999.60
Supported Employment Emergency Transportation mile	mile	10	1923.00	0.52	9999.60	
Supported Employment Emergency Transportation item	item	5	10.00	100.00	5000.00	
<b>GRAND TOTAL:</b>						7333786.65
Total Estimated Unduplicated Participants:						569
Factor D (Divide total by number of participants):						12888.90
Average Length of Stay on the Waiver:						348