

State Plan under Title XIX of the Social Security Act
State/Territory: Alabama

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Mentally Ill Adults

The population to be served consists of functionally limited individuals 18 years of age or older with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons have a DSM diagnosis from the most recently approved DSM (other than mental retardation or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing, and sustaining involvement with needed services.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
 Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;

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- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and

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- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

____ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Target Group 1: Mentally Ill Adults

The case management provider will be either Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly, or the Department of Mental Health. Providers must be certified by the Alabama Department of Mental Health. Act 310 provides for the formation of public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness, mental retardation, and substance abuse populations.

Individual case managers must meet the following qualifications:

- (A) At a minimum, a Bachelor of Arts or a Bachelor of Science degree preferably in a human services related field, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum provided or approved by the Department of Mental Health and the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- 1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

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2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
 Intellectually Disabled Adults

The population to be served consists of individuals 18 years of age or older with a diagnosis of mental retardation, as defined by the American Association of Mental Retardation (formerly AAMD).

The individual's diagnosis must be determined by a Qualified Mental Retardation Professional (QMRP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to an intellectual disability. Such persons may have other or secondary disabling conditions.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, ICFs/MR, ICFs/MR 15 bed or less, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
 ___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- ___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

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- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals

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and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Target Group 2: Intellectually Disabled Adults

The case management provider will be either Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated ability to provide targeted case management services directly, or the Department of Mental Health.

Providers must be certified by the Alabama Department of Mental Health. Act 310 provides for the formation of public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness, mental retardation, and substance abuse populations.

Individual case managers must meet the following qualifications:

- (A) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum provided or approved by the Department of Mental Health and the Alabama Medicaid Agency.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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Targeted Group 2 Intellectually Disabled Adults

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other

services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 3 Disabled Children**

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Disabled Children

The population to be served consists of individuals age 0-20 or until the individual reaches age 21 considered to be disabled as defined in the following six subgroups:

(A) Intellectually Disabled/related conditions: (Individuals in this subgroup will be age 0-17.)

(1) Intellectually Disabled - diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

(2) Related conditions - individuals who have a severe chronic disability that meets all of the following conditions:

(a) It is attributable to:

(i) Cerebral palsy or epilepsy; or

(ii) Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(i) Self-care,

(ii) Understanding and use of language,

(iii) Learning,

(iv) Mobility,

(v) Self-direction,

(vi) Capacity for independent living.

(B) Seriously emotionally disturbed:

In order to meet the definition of seriously emotionally disturbed, at least one criterion from section (1) or (2) and two from section (3) below must be met:

(1) Mental Health Treatment History:

(a) Has undergone mental health treatment more intensive than outpatient care (emergency services, inpatient services, etc.);

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- (b) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime;
- (c) Has been assigned to a program of psychotropic medication; or
- (d) Has received mental health outpatient care for a period of at least six (6) months, or for more than twenty (20) sessions, or has been admitted for treatment on two or more occasions.

(2) Indicators of Mental Health Treatment Needs:

- (a) Family history of alcohol or drug abuse,
 - (b) Family history of mental health treatment,
 - (c) Failure to thrive in infancy or early development indicated in medical records,
 - (d) Victim of child abuse, neglect or sexual abuse,
 - (e) Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, theft, etc.), or
 - (f) Runaway episode(s) of at least twenty-four (24) hours duration.
- (3) Current Functioning - problem areas of one year duration or substantial risk of over one year duration.

- (a) Is not attending school (and has not graduated), is enrolled in a special education curriculum, or has poor grades;
- (b) Dysfunctional relationship with family and/or peers;
- (c) Requires help in basic, age-appropriate living skills;
- (d) Exhibits inappropriate social behavior; or
- (e) Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, social isolation, etc.).

(C) Sensory impaired:

- (1) Blind - One who after the best possible correction has no usable vision; therefore, must rely upon tactile and auditory senses to obtain information.

- (2) Partially sighted - One who has a visual acuity of 20/70 or less in the better eye with the best possible correction, has a peripheral field so restricted that it affects the child's ability to learn, or has

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a progressive loss of vision which may in the future affect the child's ability to learn.

(3) Deaf - A hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification which adversely affects educational performance.

(4) Blind multi-need - One who has a visual impairment (as defined in (C)(1) and (C)(2) above) and a concomitant disabling condition.

(5) Deaf multi-need - One who has a hearing impairment (as defined in (C)(3) above) and a concomitant disabling condition.

(6) Deaf-blind - One who has concomitant hearing and visual impairments, the combination of sensory impairments causing such severe communication and other developmental and educational problems that they cannot be properly accommodated in the educational programs by the Alabama School for the Blind or the Alabama School for the Deaf.

(D) Disabling health condition(s) - One which is severe, chronic and physical in nature, requiring extensive medical and habilitative/rehabilitative services:

(1) Central nervous system dysraphic states, (such as spina bifida, hydranencephaly, encephalocele);

(2) Cranio-facial anomalies, (such as cleft lip and palate, Apert's syndrome, Crouzon's syndrome);

(3) Pulmonary conditions, (such as cystic fibrosis);

(4) Neuro-muscular conditions, (such as cerebral palsy, arthrogryposis, juvenile rheumatoid arthritis);

(5) Seizure disorders, (such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type);

(6) Hematologic/immunologic disorders, (such as hemophilia, sickle cell disease, aplastic anemia, agammaglobulinemia);

(7) Heart conditions, (such as aortic coarctation, transposition of the great vessels);

(8) Urologic conditions, (such as extrophy of bladder);

(9) Gastrointestinal conditions, (such as Hirschprung's Disease, omphalocele, gastroschisis);

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- (10) Orthopedic problems, (such as clubfoot, scoliosis fractures, poliomyelitis);
- (11) Metabolic disorders, (such as panhypopituitarism);
- (12) Neoplasms, (such as leukemia, retinoblastoma); and
- (13) Multisystem genetic disorders, (such as tuberous sclerosis, neurofibromatosis).
- (E) Developmentally delayed -
- (1) A child age birth to three years who is experiencing developmental delays equal to or greater than 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:
- (a) Cognitive development;
 - (b) Physical development (including vision and hearing);
 - (c) Language and speech development;
 - (d) Psychosocial development; and
 - (e) Self-help skills.
- (2) One who has a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay.
- (F) Multi-need - An individual who has a combination of two or more disabling conditions. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions would be of such severity to adversely affect development.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
___ Only in the following geographic areas:

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TARGETED CASE MANAGEMENT SERVICES

Targeted Group 3 Disabled Children

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- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Target Group 3: Disabled Children

Case management providers must be certified as a Medicaid provider meeting the following criteria:

- (A) Demonstrated capacity to provide all core elements of case management:
 - (1) assessment,
 - (2) care/services plan development,
 - (3) linking/coordination of services, and
 - (4) reassessment/follow-up.

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- (B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (C) Demonstrated experience with the target population.
- (D) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (E) A financial management system that provides documentation of services and costs.
- (F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

- (A) A Bachelor of Arts or a Bachelor of Science degree, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 3 Disabled Children

- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 3 Disabled Children

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Foster Children (Children in the Care, Custody, or Control of the State or Receiving State Agencies). The population to be served consists of children age 0-20 or until the individual reaches age 21 who are receiving preventive, protective, family preservation or family reunification services from the State, or any of its agencies as a result of State intervention or upon application by the child's parent (s), custodian(s), or guardian(s); or children age 0-20 or until the individual reaches age 21 who are in the care, custody or control of the State of Alabama, or any of its agencies due to:

(A) The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975; or

(B) The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute; or

(C) The voluntary placement agreement, voluntary boarding home agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 4: Foster Children

Case management providers must be certified as a Medicaid provider meeting the following criteria:

- (A) Demonstrated capacity to provide all core elements of case management:
 - (1) assessment,
 - (2) care/services plan development,
 - (3) linking/coordination of services, and
 - (4) reassessment/follow-up.
- (B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (C) Demonstrated experience with the target population.
- (D) An administrative capacity to insure quality of services in accordance with state and federal requirements.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

- (E) A financial management system that provides documentation of services and costs.
- (F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

- (A) A Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women**

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

The population to be served consists of Medicaid-eligible women in need of maternity services.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
 ___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- ___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Case management services are those services which will assist Medicaid-eligible pregnant women of any age in need of maternity services in gaining access to needed medical, social, educational, and other services.

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women**

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women**

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified as a Medicaid provider meeting the following criteria:

- (A) Demonstrated capacity to provide all core elements of case management:
 - (1) assessment,
 - (2) care/services plan development,
 - (3) linking/coordination of services, and
 - (4) reassessment/follow-up.
- (B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (C) Demonstrated experience with the target population.
- (D) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (E) A financial management system that provides documentation of services and costs.
- (F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

- (A) A Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women**

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women**

need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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State/Territory: Alabama**TARGETED CASE MANAGEMENT SERVICES**
Targeted Group 6 AIDS/HIV-Positive IndividualsTarget Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
AIDS/HIV-Positive Individuals

The population to be served consists of Medicaid-eligible individuals who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, or residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)Areas of State in which services will be provided (§1915(g)(1) of the Act):X Entire State Only in the following geographic areas:Comparability of services (§§1902(a)(10)(B) and 1915(g)(1)) Services are provided in accordance with §1902(a)(10)(B) of the Act.X Services are not comparable in amount duration and scope (§1915(g)(1)).Definition of services (42 CFR 440.169): Case management services are those services which will assist Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings in gaining access to needed medical, social, educational, and other services.

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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Targeted Group 6 AIDS/HIV-Positive Individuals

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Target Group 6: AIDS/HIV-positive individuals

Case management providers must be certified as a Medicaid provider meeting the following criteria:

- (A) Demonstrated capacity to provide all core elements of case management:
 - (1) assessment,
 - (2) care/services plan development,
 - (3) linking/coordination of services, and
 - (4) reassessment/follow-up.
- (B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (C) Demonstrated experience with the target population.
- (D) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (E) A financial management system that provides documentation of services and costs.
- (F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

- (A) A Bachelor of Arts or a Bachelor of Science Degree in social work from a school accredited by the Council on Social Work Education, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adult Protective Service Individuals

The population to be served consists of individuals 18 years of age or older who are:

(A) At risk of abuse, neglect, or exploitation as defined in Section 38-9-2 Code of Alabama, 1975; or mentally incapable of adequately caring for himself or herself and his or her interests without serious consequences to himself or herself or others, or who, because of physical or mental impairment, is unable to protect himself or herself from abuse, neglect, exploitation, sexual abuse, or emotional abuse by others, and who has no guardian, relative, or other appropriate personable, willing, and available to assume the kind and degree of protection and supervision required under the circumstances

(B) At risk of institutionalization due to his/her inability or his/her caretaker's inability to provide the minimum sufficient level of care in his/her own home.

A person in one of these targeted groups may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, residential programs. Targeted case management services may be provided to clients receiving case management through a waiver so long as both case managers are performing different types of activities and functions based upon the case managers' distinct focus. The case manager's documentation must provide a clear distinction between waiver case management and targeted case management activities.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

 Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

 Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

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State/Territory: Alabama

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Target Group 7: Adult Protective Service Individuals

Individual case managers must meet the following minimum qualifications:

- (A) A Bachelor of Arts or a Bachelor of Science Degree, preferably in a human services field, and
- (B) Eligible for state social work licensure or exempt from licensure.
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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Targeted Group 7 Adult Protective Service

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES

Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults.

The target group for the TA waiver is individuals who are 21 years of age or older with complex medical conditions. These individuals are ventilator-dependent or have a tracheostomy.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
 Only in the following geographic areas

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and

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Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology
Assisted (TA) Waiver for Adults**

- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up – The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contracts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and

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Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Target Group 8: Individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults.

Targeted case management providers for the individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults, must demonstrate experience with the target population in completing medical psychosocial assessments and case plans, coordination of services, provision of referral and follow-up services and be employed in a non-institutional health care setting and must be certified as a Medicaid provider meeting the following criteria:

- (A) Demonstrated capacity to provide all core elements of case management:
 - (1) assessment,
 - (2) care/services plan development,
- (3) linking/coordination of services, and
- (4) reassessment/follow-up
- (B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (C) Demonstrated case management experience with the target population.
- (D) An administrative capacity to ensure quality of services in accordance with state and federal requirements.
- (E) A financial management system that provides documentation of services and costs.
- (F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

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(G) Demonstrated ability to assure a referral process consistent with Section 1902(a)(23), freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or Bachelor of Science, or

(B) A Registered Nurse, and

(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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**TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology
Assisted (TA) Waiver for Adults**

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

**State of Alabama
Self-Directed Personal Assistance Services State Plan Amendment**

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

- A. In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.
- B. X In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

- A. State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.
- B. X Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

The following are the 1915(c) Home and Community-Based Waiver Services to be self-directed:

Elderly and Disabled Waiver: Personal Care, Homemaker, Unskilled Respite, and Companion.

State of Alabama Independent Living Waiver: Personal Care and Personal Assistance

Alabama Community Transition Waiver: Personal Care, Homemaker, Unskilled Respite, and Companion

Technology Assisted Waiver for Adults: Personal Care/Attendant

HIV/AIDS Waiver: Personal Care, Homemaker, Unskilled Respite, and Companion

iii. Payment Methodology

 X The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

- A. The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

- A. X The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- B. The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program participant may elect to discontinue participation in the *Personal Choices* program at any time.

The following procedures serve as safeguards to ensure that the reasons for disenrollment are not related to abuse or similar concerns and that services are not interrupted during the transfer from *Personal Choices* to the participant's traditional waiver program.

It is the responsibility of the participant to initiate voluntary disenrollment by notifying his/her Counselor of such a decision. The participant may notify the Counselor of his/her desire to disenroll by phone or e-mail. The Counselor will document in the participant's record, the date of notification by the participant of their decision to disenroll. The Counselor will begin the disenrollment process within **10** business days from the date of notification. A face-to-face contact is required to discuss the following:

- To provide an opportunity for the Counselor to determine if the participant's health, safety, and welfare has been jeopardized during their enrollment.
- To minimize unnecessary disenrollment if the Counselor can identify and resolve any problems that would enable continued enrollment and satisfaction with the program or confirm that the reasons for disenrollment cannot be resolved.
- To obtain the signature of the participant to attest to his desire to disenroll.

- To explain the processes and timeline for transfer back to the traditional service delivery option.
- To ascertain the participant's choice of direct service providers.
- To discuss the conversion of the individual budget back to traditionally authorized services and make necessary decisions related to accumulated funds.

From the receipt of the request for voluntary disenrollment, the timeline for transfer from *Personal Choices* to the traditional waiver, when the participant's health and safety is not in jeopardy, may be from fifteen to forty-five days. The Counselor will have 10 days to begin the process of disenrollment and the transition to the traditional waiver program. The timeline may be extended up to 45 days if requested by the participant.

Personal Choices services will continue until transition to the traditional waiver is complete unless there is an immediate health, danger or safety issue.

Once disenrolled, the participant must continue to receive traditional waiver services for a minimum of three months before re-enrollment in *Personal Choices* can be considered.

vi. Involuntary Disenrollment

- A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the *Personal Choices* program, the participant may be returned to the traditional waiver program. Participants will be given an advance notice in writing of their return to the traditional waiver service. Although the decision to involuntarily disenroll the participant from the *Personal Choices* program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on their appeal. In order to appeal, the participant/representative must follow the approved waiver appeal policies and procedures.

Program participants may be involuntarily disenrolled from the program for the following reasons:

1. Health, Safety and Well-being

At any time that the Counselor, the waiver case manager, or the Operating Agencies determine that the health, safety and well-being of the program participant is compromised or threatened by continued participation in the *Personal Choices* program, the participant will be disenrolled.

2. Change in Condition

If the participant's ability to direct his/her own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the individual will be involuntarily disenrolled from the program.

3. Misuse of Monthly Allocation

If the *Personal Choices* participant/representative choose the cash option and uses the monthly budgeted allocation to purchase items unrelated to personal care needs, fail to pay the salary of an employee, or fail to pay related state and federal payroll taxes, the participant/representative will receive a written warning notifying them that exceptions to the agreed upon conditions of participation are not allowed. The participant will be permitted to remain on the *Personal Choices* program, but expenditures will be monitored and reviewed closely by the Counselor and/or the Financial Management Services Agency (FMSA) to ensure the funds are being expended appropriately. The participant/representative will be notified in writing that further failure to misuse funds allocated through the *Personal Choices* program will result in involuntary disenrollment from the program.

4. Under-utilization of Budget Allocation

The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is under-utilizing the monthly allocation or is not using the allocation according to their Personal Support Plans, the FMSA and Counselor will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under-utilization of the budget allocation, the participant will be returned to traditional waiver services.

5. Failure to Provide Required Documentation

If a program participant/representative fails to provide required documentation of expenditures and related items as prescribed in the *Personal Choices Roles and Responsibility* tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program.

The participant/representative will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the *Personal Choices* program.

- B. The State will provide that the following safeguards are in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program participant may be involuntarily disenrolled as a participant in the *Personal Choices* program if the circumstances specified by the State occur. It is the responsibility of the Counselor to notify the waiver case manager immediately when the participants' health and safety may be jeopardized by their continued enrollment in the *Personal Choices* program. The Counselor will begin the disenrollment process as soon as practicable to ensure the health and safety of the participant and a seamless transition to the traditional waiver.

The waiver case manager must ensure that traditional services are reinstated prior to the discontinuance of the *Personal Choices* program. The waiver case manager will perform a re-assessment of the participant's level of care needs in order to resolve any identified health and safety issues.

The Counselor and waiver case manager work together to gather the following information in support of the involuntary disenrollment of the participant:

- The extent of the health and safety issue which necessitates the need for involuntary disenrollment
- To identify and resolve any problems that may enable continued enrollment or confirm that the reasons for involuntary disenrollment cannot be resolved
- To obtain the participant's signature acknowledging that they understand that they will no longer be participating in the *Personal Choices* program
- To explain the processes and timeline for transfer back to the traditional waiver program
- To determine the participant's choice of direct service provider agencies
- To discuss the conversion of the individual budget back to the traditional waiver services and make necessary decisions related to accumulated funds

Personal Choices services will continue until transition to the traditional waiver is complete.

Once disenrolled, the participant must continue to receive traditional waiver services for a minimum of three months before re-enrollment in *Personal Choices* can be considered. The Counselor and Case Manager inform the participants about the difference of being terminated from the waiver and involuntarily disenrolled from *Personal Choices* and how to appeal. *Personal Choices* participants follow the approved waiver appeal policies and procedures.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The State places no additional restrictions on participant living arrangements.

viii. Geographic Limitations and Comparability

- A. X The State elects to provide self-directed personal assistance services on a statewide basis.
- B. The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:
- C. The State elects to provide self-directed personal assistance services to all eligible populations.
- D. The State elects to provide self-directed personal assistance services to targeted populations. .

To be eligible for *Personal Choices*, the individual must:

- Be currently enrolled in either the E&D, SAIL, TA, HIV/AIDS or the ACT waiver and meet the medical and financial requirements for participation in those waivers
-

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To be a participant in *Personal Choices*, the individual/representative must:

- Give informed consent to participate
 - Be able to understand the rights, risks, and responsibilities of managing their own care or if unable to make decisions independently have a willing representative who understands the rights, risks and responsibilities of managing the care of the participant with a cash allowance
 - Be willing to complete a Personal Support Plan with the help of a counselor.
- E. X The State elects to provide self-directed personal assistance services to an unlimited number of participants.
- F. The State elects to provide self-directed personal assistance services to (insert number of) participants, at any given time.

ix. Assurances

- A. The State assures that there are traditional personal assistance services, comparable in amount, duration and scope, to self-directed personal assistance services.
- B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.
- C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
- i.* Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
 - ii.* Are entitled to and are receiving home and community-based services under a Section 1915(c) waiver; or
 - iii.* May require self-directed personal assistance services; or
 - iv.* May be eligible for self-directed personal assistance services.

- D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a Section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.
- E. The State assures that individuals will be provided with a support system meeting the following criteria:
- i.* Appropriately assesses and counsels individuals prior to enrollment;
 - ii.* Provides appropriate counseling, information, training and assistance to ensure that participants are able to manage their services and budgets;
 - iii.* Offers additional counseling, information, training or assistance, including financial management services:
 - 1. At the request of the participant for any reason; or
 - 2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.
- F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.
- G. The state assures that an evaluation will be provided to CMS every three years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.
- H. The State assures that the provisions of Section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.
- I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.
- J. The State assures that the methodology used to establish service budgets will meet the following criteria:
- i.* Objective and evidence based.
 - ii.* Applied consistently to participants.
 - iii.* Open for public inspection.
 - iv.* Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.

- v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
- vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
- vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
- viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
- ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

The State delegates the responsibility for developing the self-directed personal assistance service plan to the counselors employed by the designated Operating Agency and does not delegate any portion of that authority to any other Medicaid State Plan service provider.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

- i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
- ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

Personal Choices has been designed to promote quality in operations. The Center for Medicare/Medicaid Services' (CMS) Quality Framework is the cornerstone for monitoring and improving the quality of the program. The CMS Quality Framework focuses on a participant-centered foundation that supports access, choice, and the health and safety of the participant.

Design Elements of the Quality Management Plan for *Personal Choices*

Accountability

The Alabama Medicaid Agency will maintain administrative oversight responsibilities for the Quality Management Plan. The Alabama Department of Senior Services (ADSS) and the Alabama Department of Rehabilitation Services (ADRS) will be responsible for the actual management of quality activities defined in the plan.

The ADSS and ADRS will maintain primary oversight of the following activities and will:

- Monitor the Counselor/FMSA to the degree necessary to ensure compliance with participant direction of their care and appropriate fiscal and programmatic procedures
- Identify modifications and apply edits to the *Personal Choices* data system to create reports, prevent erroneous billing and allow a continual system of review
- Provide support to the Counselor and FMSA to enable effective training.
- Direct quality assurance activities.
-

Each of the stakeholders also has an integral role to play in quality management. These include the participant, the participant's employees, the Counselor and the FMSA as well as the administering and Operating Agencies.

Quality Improvement Committee

The Quality Improvement Committee (QIC) will monitor all aspects of quality in the *Personal Choices* program. The QIC members consist of Medicaid and Operating Agency staff. This committee will set performance indicators, review program operations and results make recommendations for program changes and develop strategies for program improvement.

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Supersedes
TN No. AL-11-005

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Education and Training

Counselors are required to receive comprehensive, competency-based training from ADSS and ADRS staff or a designee. Once trained, the Counselor will provide a comprehensive, competency-based training to all participants/representative before the individual budget is developed. Outreach and participant/representative education activities will also be provided on an as needed basis.

Training materials will be developed and modified as needed, based upon the participant's level of competency. The Quality Improvement Committee will review training materials and revise as indicated.

Discovery Elements of the Quality Management Plan for *Personal Choices*

Accountability

ADSS and ADRS will monitor all aspects of the *Personal Choices* program to assure compliance with the program requirements. The Operating Agencies will conduct participant surveys to monitor the level and quality of participant direction and the adequacy of the training curriculum to enable successful participant direction. ADSS and ADRS will respond to possible quality problems identified through any channel by establishing a Project Team to examine the available data, study the work process in question, and develop a corrective action plan. The Project Team will include a representative from the Medicaid Agency Long Term Care Quality Review Unit. ADSS and ADRS, along with the Project Team will monitor implementation of changes and subsequent data collection to determine whether problems have been resolved. Program changes will be reviewed during the quality meeting with the Operating Agencies.

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Performance Indicators

The Performance Indicators will be used to measure program performance that may occur at the service or provider level. The Performance Indicators are the tools utilized to monitor and track program activities and processes to ensure that participant choice and satisfaction in services and service delivery is achieved. The Performance Indicators are person-centered and focus on positive outcomes for the participants.

The Performance Indicator Reports will describe the results of data gathered using the Performance Indicators, the source of the data, the frequency in which the data is reviewed, and who assists in analyzing the data.

The Performance Indicator Reports will ensure the following key components:

- Enrollment processes are proceeding as planned.
- Enrollees receive their first allowance payment timely.
- Number of disenrollments are minimized.
- Costs of providing *Personal Choices* services are comparable with the cost of providing the EDW, SAIL, TA, HIV/AIDS and ACT Waiver services.
- Participants are satisfied with their care arrangements and paid caregivers
- Unmet needs of participants are provided through the program.
- Participants' health is not adversely affected

Remediation and Improvement Elements of the Quality Management Plan for Personal Choices

Incident Management and Abuse Prevention

The plan for the *Personal Choices* program is defined in policy and is the responsibility of the Operating Agencies. The procedures are consistent with current Alabama State law and reporting procedures. To further ensure the participants' health and safety, criminal background checks of providers at no cost to the participant will be required.

Operating Agency staff will be tasked with the review and management of incidents, complaints, or grievances on an ongoing basis and will follow established guidelines for reporting and follow-up as set forth by the Medicaid Agency. In addition, findings will be reported at the Operating Agencies quarterly quality meeting. Operating Agency staff will serve as the Incident Management Review team and will be tasked with the quarterly review of all incident reports. Operating Agency staff will develop recommendations or changes to the program, and monitor the program changes to ensure implementation.

All participants, family members, and Counselors will receive training in incident reporting and management before receiving or providing services. The core elements of the training will provide information on reporting abuse, neglect, and exploitation, how participants can report incidents, and to whom to report incidents.

xii. Risk Management

- A. The risk assessment methods used to identify potential risks to participants are described below.

Participant Protections

The *Personal Choices* program will provide participant protections to include: information to participants, participant training and skills assessment, counseling services, financial management services, development of emergency back-up plans, development of an incident reporting system and access to program staff. Participants are required to use counseling and financial management services in order to assume responsibility for their care and financial management. The Counselor will train, coach, and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget to effectively meet their care needs, avoid overspending as well as prevent the under-utilization of their allocated budget.

The FMSA, as the employer agent, will assist participants to pay their employees and assure compliance with state and federal labor and tax laws. The FMSA will provide a method of receiving funds from the state and making the funds available for the participants' budgets.

Orientation

An orientation to the *Personal Choices Participant Handbook* is required for all participants prior to the disbursement of the initial monthly budget. The intent of the orientation is to provide participants with the tools they need to effectively and safely manage their services. Counselors will be responsible for providing this mandatory training session for participants enrolled in the program. Participants will receive a program manual to provide additional information to support the training objectives.

During this orientation, risks are identified and risk mitigation plans are developed through the use of three primary tools: 1) the *Personal Choices Rights and Responsibilities*, 2) the *Self-Assessment* and 3) the *Risk Assessment Checklist*. In addition, participants are provided the *Personal Support Plan* tool, to assist them in identifying others resources who may be able to provide help and support and thereby also mitigate risk. One of the most important uses of this tool is in the development of a back-up plan but the tool may also be used to address other risk issues.

Back-up Plan

Personal Support Plans **must** include an emergency backup plan identifying the arrangements that have been made for the provision of services and/or supplies in the absence of critical planned services and supports. Each *Personal Choices* participant is required to develop a back-up plan as part of his Personal Support Plan. The back-up plan should describe the alternative service delivery methods that will be used under either of the following circumstances: 1) if the primary employees fail to report for work or otherwise cannot perform the job at the time and place required, 2) if the participant experiences a personal emergency, or 3) if there is a community-wide emergency (e.g., requiring evacuation). The personal emergency portion of the Back-up plan will allow the participant to identify circumstances that would cause an emergency for him based upon his unique needs. The back-up plan must also address ways to assure that the needs of the individual are met should an unexpected shortage of funds occur. The back-up plan should also address if the representative is no longer able to serve as the participant's representative. The Counselor must attest to the viability of the back-up plan before services can begin and the budget is released.

Case Managers and Counselors will discuss emergency protocol with the client prior to entry into the *Personal Choices* Program. In the event of a disaster, the *Personal Choices* participant will have access to assistance from the Alabama Emergency Management Agency (EMA). In the event of a disaster, Case Managers/Counselors will coordinate with EMA on all *Personal Choices* participants who are high risk or participants with special needs in order to assure that EMA has expedient access to the participant in a threatening situation.

Representatives

Participants may choose to manage their own personal support plans, or may appoint a representative to assist them. Counselors and outreach staff will provide and/or make available education and information to enable either model. All participants have the option of choosing one individual to act as a representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities.

Representatives may not work for the participant or be paid by the participant with monthly budget funds. Participants may also receive assistance with their *Personal Choices* responsibilities without appointing a friend, caregiver, family member, or other person as a representative, but these individuals cannot sign documents, speak for or otherwise act on behalf of the participant.

B. The tools or instruments used to mitigate identified risks are described below:

There are three levels of risk assessment used to identify potential risks to participants.

Level 1: HCBS Waiver Assessment

Participants in the *Personal Choices* program must be participants in the E&D, SAIL, TA, HIV/AIDS or ACT waivers. Therefore, prior to enrollment in the *Personal Choices* program, each participant will receive an HCBS waiver plan of care based on an assessment of need as determined by the HCBS Waiver Assessment tool that includes an identification of risks and potential mitigation strategies. The waiver case manager will continue to play a role in the participant's overall plan of care through the HCBS traditional waiver, and will continue to assess needs and risks as required by the respective waiver protocol.

Level 2: Orientation Self Assessment

All participants in *Personal Choices* must take part in an initial orientation prior to the release of the budget. This orientation begins with a self-assessment process, using three tools.

The first tool is the *Personal Choices Participant Handbook* which provides a detailed description of the roles and responsibilities of the participant in the program including a detailed description of the roles, responsibilities and support functions of the Counselor and FMSA. This document will be thoroughly reviewed with the participant and/or the representative to ensure that there is a clear understanding of the responsibilities related to the health and safety and mitigation of risks to be assumed by the participant.

The second tool is the *Self-Assessment*, which asks participants to indicate their understanding and ability to implement each of the roles and responsibilities detailed in the *Personal Choices Participant Handbook*. Depending on the responses, the Counselor and participant will formulate a plan for ensuring the participant can effectively manage each of the roles and responsibilities. Other potential strategies may include additional training and/or the use of an informal or formal representative.

The third tool is the *Risk Assessment Checklist*. This instrument lists many common risk factors, ranging from physical and cognitive disabilities to social issues such as isolation. For each identified risk, the participant is alerted to the nature of the potential risk and prompted with examples to develop a plan to mitigate that potential risk.

Level 3: Ongoing Monitoring by Counselor and FMSA

The Counselor will monitor the Personal Support Plan to ensure that participation in the program does not compromise the health and well being of the participant. The Counselor will initiate contacts to the participant as needed to monitor the quality of self-directed care, to provide support and assistance, and to assure that essential needs are met. These contacts will be conducted as needed, but not less than monthly during the first six months of participation.

The FMSA will document at least monthly amounts spent for each participant/representative receiving an allowance to assure that money is spent on appropriate items identified in the Personal Support Plan, or for items related to personal care needs when discretionary funds are spent. Monitoring may be performed more frequently whenever problems or potential problems are identified. Problems associated with the monthly allowance such as misuse or under-utilization of the funds, failure to pay assistants as required, failure to comply with applicable state and federal employer laws, failure to submit documentation of expenditures, theft of checks mailed to participant/representative or other problems will be reported in writing to the Operating Agencies immediately.

- C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Individuals who choose to participate in the *Personal Choices* program will be provided with individualized supports to enable them to manage their own services to the largest extent possible.

These supports, and the manner in which they will be delivered, will be generated from a person-centered planning process facilitated by the Counselor utilizing the Self Assessment tool.

The participant/representative will develop a Personal Support Plan to specify how the monthly budget will be used to meet the participant's care needs, and how other identified needs might be met through generic and community supports. Information from the Self Assessment tool that takes place during orientation will serve as a primary source of information regarding potential risks and the plans that are developed to mitigate the risk. The results of this process will be documented in the service plan and updated annually or more frequently if needed.

- D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

Counselors will provide support for technical assistance in order to facilitate the development of the risk management plan by the participant/representative, if any, and others from whom the participant may seek guidance.

Counselors will not assume responsibility for developing the risk management plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the participant's needs, and that an emergency back-up Plan is in place. Additionally, the Counselor will assess the overall Personal Support Plan for potential risks and risk mitigation strategies. The Counselor reviews the proposed personal support plan with the participant/representative and others identified by the participant as a method to assess the participant/representative's ability to assume service management responsibilities and to further generate discussion around risk management.

xiii. Qualifications of Providers of Personal Assistance

- A. X The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.
- B. The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

- A. X The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.
- i. The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.
- B. The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

- A. X The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.
- B. The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

- A. X The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.
- i.* The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or
- ii.* X The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR Section 74.40 – Section 74.48.)
- iii.* The State elects to provide financial management services using “agency with choice” organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.
- B. The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State of Alabama
Program of All Inclusive Care for the Elderly (PACE) State Plan Amendment

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

Individuals receiving services under this program are eligible under the following eligibility groups:

- A Special Income level equal to 300% of the SSI Federal benefit (FBR) (42 CFR 435.217)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

- (3) Family (check one):
(a) ___ AFDC need standard
(b) ___ Medically needy income standard

The amount specified below 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 435.811 for a family of the same size.

- (c) ___ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
(d) ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
(e) ___ The amount is determined using the following formula:

(f) ___ Other
(g) ___ Not applicable (N/A)

(B) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

B. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. **42 CFR 435.735**--States using more restrictive requirements than SSI.

- (A) Allowances for the needs of the:
(1) Individual (check one)
(a) ___ The following standard included under the State plan (check one):
(i) ___ SSI
(ii) ___ Medically Needy
(iii) ___ The special income level for the institutionalized
(iv) ___ Percent of the Federal Poverty Level: _____ %
(v) ___ Other (specify): _____
(b) ___ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.

3. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(2) Spouse only (check one):

(a) ___ The following standard under 42 CFR 435.121:

(b) ___ The Medically needy income standard

(c) ___ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

(d) ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

(e) ___ The amount is determined using the following formula:

(f) ___ Not applicable (N/A)

(3) Family (check one):

(a) ___ AFDC need standard

(b) ___ Medically needy income standard

The amount specified below 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 435.811 for a family of the same size.

(c) ___ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

(d) ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

(e) ___ The amount is determined using the following formula:

(f) ___ Other

(g) ___ Not applicable (N/A)

(C) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

C. ___ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

1. Allowances for the needs of the:

(A) Individual (check one)

(1) ___ The following standard included under the State plan (check one):

(a) ___ SSI

(b) ___ Medically Needy

(c) ___ The special income level for the institutionalized

(d) ___ Percent of the Federal Poverty Level: ___ %

(e) ___ Other (specify): _____

(2) ___ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

(3) ___ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

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II. Rates and Payments

- A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.
1. Rates are set at a percent of fee-for-service costs
 2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
 3. Adjusted Community Rate (please describe)
 4. Other (please describe)
- B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
- C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

RATE METHOD

Program of All-inclusive Care for the Elderly (PACE) For Sites Operating Under Medicare and Medicaid Capitation

Alabama's monthly capitation rate for PACE services is set at 85% of current costs to AMA for a comparable fee-for-service population.

Rates are established by using a combination of the following data which constitutes the Upper Payment Limit (UPL):

Nursing Facility Cost

The nursing facility cost consists of the most recently available statewide average AMA nursing facility annual cost per recipient. (yearly amount reimbursed to AMA nursing facility providers for nursing facility residents, divided by the total number of AMA nursing facility residents in a year; multiplied by the average length of stay).

And

Cost of Other Services

Cost of other services consists of the most recently available statewide average cost of all claims paid for non-nursing facility services or non-waiver services for eligible recipients. (yearly amount reimbursed for institutionalized/waiver recipients for services included in capitation divided by the number of eligible recipients).