Alabama's Community Waiver Program
1915(c) and 1115(a) Demonstration

Annual Monitoring Report- **DRAFT**

10/01/2021 – 09/30/2022

Contents

Introduction

The Alabama Department of Mental Health - Division of Developmental Disabilities (ADMH/DD) received final approval of its new Community Waiver Program (CWP) from the Centers for Medicare and Medicaid Services (CMS) on October 21, 2021, and officially launched on November 1, 2021. This Waiver created a new Home and Community-Based Services (HCBS) program to serve individuals with intellectual disabilities (ID) in a way that is specifically geared toward maximizing their abilities while supporting their full participation in their communities, including opportunities for integrated employment, and ensuring supports for preserving their natural and existing living arrangements to the fullest extent possible. This new HCBS program was created through the concurrent operation of an 1115 Demonstration application and a waiver application under Section 1915(c) of the Social Security Act. The CWP operates in eleven counties throughout all five ADMH/DD regions of the state.

With a November 1, 2021, launch, ADMH/DD successfully completed one partial quarter aligned with the CMS approval date and three full quarters, ending year one on 9/30/2022.

Throughout the year, the CWP staff, ADMH/DD leadership, the Alabama Medicaid Agency (AMA), CWP subject matter experts, and CWP consultants worked in partnership to implement and advance the priorities established in the CWP:

- Find a way to end the waiting list for people in Alabama with intellectual disabilities.
- Serve people before they get into crisis to keep them from getting into crisis.
- Focus on keeping families together by offering services/supports designed to assist the individual and services/supports designed to assist the family.
- Prioritize services that individuals and families say they need most.
- Use strategies to provide services more cost-effectively so that more people who need the services can receive them.

During the first demonstration year, the CWP saw a number of successes, as detailed in the individual success stories and performance metrics included in this report. While taking a new and distinctly different approach to operating a HCBS program for people with ID has created a sizeable learning curve and philosophical shift for ADMH/DD, 310 boards, and providers, the CWP has gained traction in the counties where it currently operates and is beginning to demonstrate the benefits of this new and different approach.

Like any new program, there were day-to-day challenges that impacted the program. However, the unexpected COVID-19 pandemic and the crippling workforce shortage that ensued have created challenges beyond those otherwise expected to come with the launch of a new program. Overall, the primary challenges in year one fell into the following categories:

a. Workforce
b. Enrollment-Eligibility
c. Provider Claims Approvals and Timely Payments to Providers
d. Appropriate Program Capacity and Expertise to Respond to Verified Emergency Referrals

The details of these challenges and the State's efforts to date, as well as planned efforts going forward, to address these challenges are discussed in this report. Looking forward to year two, the State anticipates being able to expand the CWP sooner than originally anticipated, creating more capacity to remove people with ID from the waiting list than would otherwise have been possible under the legacy Intellectual Disabilities (ID) and Living at Home (LAH) waivers. For the first time, a viable pathway is available to end the current waiting list in the counties served by the CWP, which accounted for nearly 70% of the statewide waiting list when the CWP started. If the above noted primary challenges can be effectively addressed, the elimination of the waiting list in the CWP counties is expected to be possible by the end of the third year of the CWP (9/30/24).

STC 41: Operational Updates

Operational Accomplishments

Below are the operational accomplishments ADMH/DD achieved in the first year of CWP implementation.

Outreach

ADMH/DD launched the CWP with newly appropriated funding from the Alabama legislature, allowing for the initial creation of 500 enrollment slots and providing for the elimination of 25% of the statewide waiting list. At the end of year one, interest in the CWP was very high among those persons with ID on the waiting list who reside in the eleven CWP counties, and 378 slots were accepted by these individuals. Of the 125 remaining slots, 68 were designated reserve capacity, leaving only 54 that did not have a person with ID identified for them. Twenty-one (21) of these 54 slots are slots in the 1115 demonstration enrollment group (Group 5) for individuals with ID who, prior to the opening of the CWP, would not have qualified to be placed on the ID waiting list. Therefore, across all 5 regions and 11 counties where the CWP operates, only 33 slots did not have a person with ID from the waiting list identified for them.

While the goal of enrolling 500 individuals with ID by the end of year one was not met, and actual total net enrollments achieved for the demonstration year was 173, this was not due to lack of interest in the CWP among those individuals with ID on the waiting list. The primary explanations for the low enrollments in year one were: (1) ongoing issues with gathering and updating eligibility documentation necessary to facilitate enrollment; and (2) lack of an effective outreach strategy for Group 5 and overly narrow eligibility criteria for Group 5. These challenges, along with solutions identified/implemented, are discussed in more detail under the section "Policies and Administrative Difficulties in Operating the Demonstration" in this report.

As of the end of year one, there were still approximately 800 individuals with ID residing in the eleven CWP counties that were waiting for Home and Community-Based Services. Each year, in the counties where the CWP is now operating, ADMH/DD estimates based on historical trends that more than 100 new individuals with ID will be added to the waiting list. The effective outreach strategies used with the waiting list will continue given that these strategies resulted in a slot acceptance rate of roughly 70% among those individuals with ID on the waiting list who were contacted about enrolling in the CWP. As noted in the introduction, ADMH/DD now has a viable pathway to end the current waiting list in the counties served by the CWP by the end of the third year of the demonstration (9/30/24).

Avoidance of Unnecessary Residential Placements

In the first year of the demonstration, there was an increase in requests for emergency residential placements as the year progressed, which appears to correlate with an overall increase in enrollments during the year and increased awareness of the CWP among referral sources (e.g., in-patient facilities; Alabama Department of Human Resources). All such requests are considered by the CWP Special Review Team, which prioritizes finding the least restrictive, most integrated solution for each individual that meets the program goals. This has proven to be a successful strategy for avoiding unnecessary residential placements.

For example, for Q4, 70% of the requests were not actually emergencies, and these individuals' goals/outcomes and related needs were able to be safely and appropriately addressed in one of the other CWP enrollment groups.[1] In Q4, the CWP successfully served 10 of 20 CWP-eligible referrals for emergency residential placement in enrollment groups 1, 2, or 3, avoiding more restrictive residential placements for these individuals while meeting their immediate need for services and supports. Only six (30%) were determined to require residential services and enrollment in Group 4. A total of three (3) individuals appealed the determination that they could be safely and appropriately served without the use of residential placement, and these appeals are still in process. These individuals were offered but declined enrollment in groups 1, 2, or 3. They may reconsider such enrollment at any time.

[1] Data from quarters 1 through 3 were determined too small to be used for evaluation and are therefore not reported.

Year one Q4	Referrals Classified as Emergency by Referral Source	Referrals Denied CWP Enrollment Due to Failure to Meet Enrollment Criteria	Referrals Determined to be Emergencies and Approved for CWP Group 4 Enrollment	Referrals Classified as Emergency by Referral Source that were Able to be Enrolled and Served in CWP Enrollment Group 1, 2 or 3, based on age.	Referrals Classified as Emergency by Referral Source that were Determined Ineligible for CWP Group 4 Enrollment and Declined Option to Enroll in Group 1, 2 or 3, based on age.	Appeals in Process
Q4 TOTAL	**24**	**4**	**6**	**10**	**4**	**3**
Region 1	5	0	0	3	0	0
Region 2	2	0	1	0	0	0
Region 3	6	0	1	4	0	0
Region 4	1	0	0	1	1	0
Region 5	10	4	4	2	3	3

Employment Outcomes

A priority for ADMH/DD is the expansion of employment opportunities and the competitive integrated employment participation rate for individuals receiving waiver supports. However, expansion is slow. The 2018-2019 National Core Indicator data from prior to the launch of the CWP estimates the rate of competitive integrated employment for Alabama ID waiver participants at under 4%. In 2020, also prior to the launch of the CWP, the National Survey of State IDD Agency Day and Employment Services found that, while 20% of the individuals who received a day or employment service in Alabama were participating in supported employment services, including both individual and group supported employment services,[2] this data reflected receipt of services rather than actual participation in employment. In addition, the data showed that supported employment services only accounted for 1% of the ADMH/DD investment in employment and day services for waiver participants.[3]

With increasing competitive integrated employment being a priority in the CWP, the program uses an enrollment priority category that reflects individuals desiring to find and keep competitive integrated employment.[4] Based on initial outreach to the waiting list prior to the opening of the CWP, 47% of individuals who requested a slot in the CWP indicated a desire to obtain competitive integrated employment. Of working age (14-64) individuals enrolled at the end of year one, 53.6% were enrolled with an enrollment priority to find/keep competitive integrated employment. The competitive integrated employment rate at the end of year one was 9.4%.[5] With most of the first-year enrollments occurring in the second half of the year, this is a promising start in terms of a rate of competitive integrated employment achieved in a year where the average length of enrollment was less than six months.

[2] https://www.statedata.info/statepages/Alabama

[3] https://legacy.nationalcoreindicators.org/upload/core-indicators/AL_IPS_state_508.pdf

[4] Enrollment Priority: (1) On waiting list; age 21 and older; goals to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment if under age 65, (2) On waiting list; age 21 and older; goal to preserve current family/independent living situation, (3) Not on waiting list; age 21 and older; goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment if under age 65, (4) Not on waiting list; age 21 and older; goal to preserve current family/independent living situation, (5) On waiting list; transition age 16-21; goal to obtain/maintain competitive integrated employment at exit from high school, and (6) Not on waiting list; transition age 16-21; goal to preserve current family/independent living situation and goal to obtain/maintain competitive integrated employment at exit from high school.

[5] This percentage differs from the percentage reported in the evaluation section of this report. The percentage quoted here was determined after manual verification of missing data and correction of reporting errors and omissions relating to employment status, based on comparing other data entered into the assessment. These data validation processes were not applied to the administrative data used for the evaluation report due to the need for a consistent approach that can be applied across years and to both CWP and legacy waiver enrollment. The CWP competitive integrated employment rate reported in the evaluation therefore differs from the figure reported here.

Collaboration with Alabama Department of Rehabilitation Services - ADRS

ADMH/DD is working collaboratively with the Alabama Department of Rehabilitation Services (ADRS)/ Alabama Vocational Rehabilitation (VR). During year one, both VR Supervisors and VR Counselors were trained on the CWP. VR assigned a liaison counselor in each CWP county to ensure consistency with the referral, acceptance, and service delivery process. Overall, the collaboration between ADMH/DD and VR is working with no significant complaints or concerns.

ADMH/DD continues to partner with VR to sponsor a 3-day certificate-based, customized/supported employment training in which both VR and ADMH/DD agencies providing employment services participate. While the CWP also requires additional training for employment service delivery, the collaboration on this training continues to strengthen the partnership between the two agencies. Also, this onsite training provides employment staff from the community provider agencies an opportunity to network and establish relationships.

Post-Award Public Forum

The Community Waiver Program held a Public Forum on April 13, 2022, at 10:00 a.m. and 1:00 p.m. Each session was well attended and included family members, service providers, and other stakeholders from around the state. There were multiple questions and comments noted from participants. Following the forum, ADMH/DD provided a formal response to each question or comment.

Comments fell into one of the following discussion points:

1. Self-Directed Services (SDS).
2. Enrollment challenges and staffing challenges preventing achievement of year one goals.
3. Need for better marketing and outreach of the CWP, including more regularly scheduled stakeholder events.
4. Clarification of services available in the CWP and how these services might differ per enrollment group.

Following the forum, ADMH/DD made some internal changes, discussed in the “Policies and Administrative Difficulties in Operating the Demonstration” section of this report, that immediately resulted in a substantial increase in enrollments into the CWP. Further, the website continues to be updated, and CWP leadership continued to present at workshops, conferences, and transition meetings. ADMH/DD developed a brochure to share with individuals and families as well as other stakeholders. Also, ADMH/DD will establish a formalized stakeholder advisory group for the CWP and meet quarterly starting in the second year of the demonstration.

Stakeholder Engagement

In September 2022, ADMH/DD hosted an additional meeting with stakeholders, which was attended by individuals and family members receiving CWP services, representatives from the state’s protection and advocacy agency, representatives from the state’s People First Chapter, faculty from Alabama State University, and others. The discussion with stakeholders addressed the ongoing work to increase enrollments as well as the plan to expand the capacity of the CWP using attrition slots from the ID and LAH waivers, in order to eliminate the waiting list in CWP counties. This meeting with stakeholders was extremely positive and as a result, ADMH/DD will convene stakeholder meetings on a quarterly basis starting in year two of demonstration.

Additionally, this meeting resulted in the resolution of an issue for one person who is deaf/blind and receiving CWP services. Her mother voiced concern regarding the State’s ability to offer Support Services Providers (SSPs) to address the participant’s communication needs. From this meeting, ADMH/DD initiated a follow-up meeting with the CWP participant, her mother, CWP leadership, and the Alabama School for the Deaf and Blind (AIDB). During this meeting, the participant and family chose to self-direct their services and identified staff that can be trained in SSP. This training will be coordinated through the partnership with AIDB. The participant is already working with VR and received approval to attend the Helen Keller National Center for Deaf-Blind Youth and Adults (HKNC) for a comprehensive technology and vocational assessment, which will be utilized to plan her services moving forward. The CWP Support Coordinator will serve as the point of contact for ongoing collaboration meetings between the CWP, AIDB, VR, and the HKNC. This is the

first deaf/blind individual served in the CWP, and the success of the collaboration described in this section resulted in a new partnership with AIDB, which can assist future enrollees in the program.

Person-Centered Assessment and Planning

Each new CWP Support Coordinator (SC) must complete an initial person-centered assessment and planning (PCAP) training. The training is designed to share the purpose and philosophy of the PCAP process, how to effectively customize the process to each person served, standards for the PCAP process, and the person-centered plan (PCP), aligning with CMS standards.[6] Currently, the CWP has 23 Support SCs who have successfully completed the training. During the first demonstration year, the training was lengthened from four (4) days to six (6) days.

The HCBS Settings Rule training was incorporated to the Person-Centered Planning Training for all Support Coordinator agencies serving the ADMH/DD waivers for people with IDD and this was one reason for the lengthening of the training. This Person-Centered Planning Training includes federal regulatory requirements for person-centered planning and the PCP document. The training incorporates specific competencies into each training day, with all competencies addressed within a 30-day timeframe. This also includes review of PCP Training follow-up materials (i.e., 60 & 90 days after initial PCP Training).

This training not only addresses the importance of person-centered planning and the HCBS Settings Rule, but demonstrates what compliance looks like in practice for individuals served. In addition, understanding of the PCP rules and guidance created by federal and state agencies is essential to heighten Support Coordinators' awareness about the role they play in the development of the PCP, maintaining compliance with the HCBS Settings Rule, and improving the experiences of CWP participants.

This comprehensive on-boarding training teaches Support Coordinators:

- Strategies to assist the individual to identify his/her personal goals/outcomes and, with the help of involved family/natural supports, define measurable person-centered strategies to pursue and achieve the identified goals/outcomes. This also includes assuring back-up and contingency plans are identified and documented in the PCP.
- How to work with the individual and his/her natural supports to identify the specific supports the person needs to achieve his/her desired goals/outcomes and maintain community living in the least restrictive, most integrated setting that can meet the person's needs.
- How to identify and leverage supports and services outside of the waiver, as well as waiver services, including the option to self-direct one or more services, to address all identified goals/outcomes and related needs.
- How to document the outcome of the PCAP in the written PCP.

In addition to training, ADMH/DD implemented the following steps in demonstration year one to ensure high quality PCAP processes and PCPs:

- Post-training testing provides confirmation of the Support Coordinator's aptitude and knowledge in successfully conducting the PCAP process and developing PCPs.
- A PCAP and PCP "Tips Tool" was developed to assist Support Coordinators in ensuring that all fields in the person-centered assessment and PCP are appropriately filled out.
- All documentation of the PCAP process and all PCPs are being reviewed by the Support Coordinator's immediate supervisor using a standardized review tool developed to ensure quality.
- When a remedial need is identified by a supervisor, or if a PCP is randomly selected for quality review, the CWP Director of Support Coordination conducts a second level review.

As a result of the implementation of this set of strategies during demonstration year one, PCPs are being approved within the sixty-day (60) timeframe established in the waiver, with minimal areas of correction needed. Per 1115 evaluation data, the use of non-Medicaid strategies, services and supports to enable a CWP participant to pursue and achieve his/her identified goals/outcomes is higher than in the legacy waivers.

[6] 42 C.F.R § 441.301(c)

Throughout the year, SCs also participated in targeted topic-specific trainings related to the implementation and monitoring of PCPs; emergency referrals; provider service documentation expectations; self-directed services; ADRS participation in supporting needs for Minor Home Modifications and Assistive Technology; use of annual budgeting tool for authorized waiver services; and Alabama Division of Intellectual Disabilities Information System (ADIDIS) billing system training. Additionally, ADMH/DD established an annual in-person CWP team meeting bringing together all ADMH/DD staff and all CWP Support Coordinators.

Enrollee Success Stories

The CWP positively impacted the lives of many people in the state of Alabama during the first year of the demonstration period. Below are some of the program's success stories.

J.F.

J.F. is a 32-year-old male with intellectual disabilities and a history of epilepsy, who up until the Summer of 2022, resided in the state of Florida where he received Medicaid Waiver services. His aging parents decided to move to Alabama in 2021 to assist with the medical care of their daughter. The decision was stressful for the parents, as the move was necessary to provide needed support to one child, while leaving another in Florida. Mom immediately began developing a plan to have J.F. join the family in Alabama. She quickly learned waivers cannot transfer from one state to another. She contacted ADMH/DD to discuss waiver services and the process to apply, including eligibility. J.F. was placed on the statewide waiting list. Mom maintained regular communication with both the 310-support coordination agency as well as the CWP Director and Director of Support Coordination. She wanted to ensure a smooth transition to Alabama before terminating her son's waiver services in Florida.

J.F. had a good life in Florida. He lived in his own apartment with a roommate. He loved participating in broadcasting at Florida State University. He was involved in a variety of community activities and held a job. Following some work with the Alabama Medicaid Agency to ensure active Medicaid, J.F. enrolled into the CWP in the Fall of 2022. He became the first person to enroll into the CWP in Alabama after terminating waiver services in another state. He met priority categories for the CWP because of his strong desire to live independently in his own apartment with supports and continue to work through a job transfer with Publix or obtain a new job.

J.F. is now self-directing his services and lives in his own apartment with both staff supports and remote supports. He was able to transfer his job to the local Publix and works 16 to 24+ hours per week. He recently began volunteering in the Broadcasting Department at a local university, and his mom is working closely with the university to recruit college students as self-directed workers to support J.F.. With both personal assistance at home and remote supports, he is living independently and reports that he is very happy to be in Alabama.

C.B.

C.B. has Down Syndrome and is diagnosed with a moderate intellectual disability. She receives the following CWP services: Independent Living Skills, Community Integration Connections and Skills Training, Community Transportation, and Breaks and Opportunities.

As a result of her desire to work, C.B. was referred to ADRS for VR services. The CWP has established a positive collaboration and partnership with Alabama VR to ensure people are provided needed supports for supported employment and development. Those providing C.B.'s employment services quickly learned that she wanted to work at her favorite fast-food restaurant, Cook Out, a restaurant chain offering a variety of menu options ranging from chicken to burgers. She began her first day of employment in the Summer of 2022 and works 12 hours per week. She is assigned to preparing food and is earning $11 an hour. C.B. tells everyone, "This is the best wage I've ever had."

A.W.

A.W. was born in Chicago, Illinois. She lived in a provider-controlled residential setting in Illinois from 1990 until 2005. While there, A.W. worked with a small mobile cleaning crew and found her passion for cleaning. A.W. and her mother decided to move to Alabama to be closer to family. A.W. and her mother applied for waiver services through ADMH/DD, and A.W. was added to the waiting list for services in the Fall of 2005. When the CWP was launched, A.W. had been on the waiting list for more than 17 years. The local 310 Support Coordination Agency reached out to A.W. and her mom to see what CWP services and supports she desired. A.W.'s first words were, "I want a job cleaning."

After enrolling into the CWP, A.W. was referred to VR for employment assistance. She chose a local Arc to provide her employment services. Following Discovery, A.W. interviewed with a local hotel in her hometown. This hotel had recently hosted a large reunion for her family, and she thought it would be a great place to work. She was immediately hired following the interview.

A.W. started working, and everyone immediately recognized and appreciated her work ethic. The Housekeeping Supervisor enjoyed working with her so much that she set A.W.'s work schedule to be the same as hers so they could work together. A.W.'s first day at work was in the Summer of 2022, and she is making $13.00 an hour. She started working 15 -20 hours a week but quickly requested more hours. She is now working 25 – 28 hours a week. A.W. has connected with a Social Security Benefits Counselor to assist her with her benefits. The hotel recently stated that having A.W. on staff has contributed to their success and keeps patrons returning to the hotel.

J.B.

J.B. was one of the first enrollments into the CWP. He experienced ongoing difficulties living in his family home. The difficulties resulted in multiple hospitalizations because of inappropriate and aggressive behaviors. After his last hospitalization, his family identified the need for more support in another residential setting. The local 310 Support Coordination Agency reached out to ADMH/DD to discuss enrollment into the CWP. The initial request from the 310 agency was the need to locate a group home for J.B.. After enrolling him into the CWP and working closely with him and his family, J.B. was able to reunite with his father and lease his own apartment. J.B. invited his father to live with him in this apartment. His father has proven to be a positive natural support. J.B. quickly got involved in the life of his community and expressed interest in finding a job. J.B. was referred to VR, completed Discovery, and obtained competitive employment at the local university. J.B. credits the CWP for his ability to live and work in his community.

K.S.

K.S. had been under the watchful eye of the Alabama Department of Human Resources (DHR) for an extended period due to ongoing concerns with her health and safety. Prior to the Summer of 2022, she received services through the ADMH/DD Living at Home waiver (LAH). This waiver allowed her to receive day services through a local provider in her county. However, her family situation at home continued to decline. There were several health and safety concerns. If left in her home, both DHR and her Support Coordinator requested an emergency CWP slot for Community residential services. She was the first Waiver participant to transfer from the LAH Waiver to the CWP. following the criteria in the ADMH/DD Operational Guideline on waiver transfers.

K.S.'s move into a community residential program resulted in some immediate improvements in her overall health and welfare. K.S. indicated she was satisfied with her new living situation and developed a close friendship with her roommate. Unfortunately, her physical and medical needs are complicated, but she is working closely with a nurse who does a great job with assisting her to maintain her medical regimen. K.S. now has control over her personal resources and makes choices on how to spend her money. She is involved in the life of her community, including participating in an exercise program and volunteering at the Humane Society.

H.P.

H.P., a 34-year-old woman, considered an emergency referral, resided with her mom and five others in a crowded apartment. Her mom provided H.P. with a very caring but very sheltered experience. Her mom became terminally ill, and a church member provided H.P. with a temporary place to stay. She was enrolled in the CWP. Initially the Support Coordinator felt community residential services would best meet H.P.'s needs. Instead of a group home placement, the CWP enabled H.P. to move into her own apartment with supports.

H.P.'s mom passed away a few months ago, and she is participating in counseling to support her through this difficult time. Her overall adjustment to living independently has been positive. Remote supports are a significant part of H.P.'s success. Sensors, video doorbell, and two-way video devices allow staff to check in with H.P., and she can text back and forth with them. She can arm and disarm her supports at bedtime and when she awakens. H.P. constantly indicates she loves her apartment and does not ever want to leave. She was also recently referred to VR to explore her options for obtaining employment. She is one of the first waiver participants in Alabama to benefit from remote supports.

Services Most Utilized

Through data analysis conducted during the first demonstration year, the services most requested by CWP participants thus far, across all five regions, were identified as follows:

- Assistive Technology and Adaptive Aids
- Breaks and Opportunities (Respite)
- Community Integration Connection and Skills Training
- Community Transportation
- Independent Living Skills
- Personal Assistance Community
- Personal Assistance Home

This pattern of requested services is aligned with expected utilization in a program focused on keeping families together, supporting community integration and enabling people to maximize independence.

Policy and Administrative Difficulties in Operating the Demonstration

ADMH/DD Administrative Staffing Challenges, Underlying Causes, and Strategies to Address Challenges

ADMH/DD continued to address staffing challenges throughout year one. The original CWP Director who worked closely with CWP consultants, pre-CMS approval, retired two months prior to the approval. As a result, a new CWP Director was recruited. Other staffing challenges and changes included retaining sufficient Quality Enhancement (QE) staff. Initially, two QE staff members were hired with plans to hire a third. These two staff members vacated these positions, though one was promoted to another CWP position. Since that time, three additional QE staff members were hired. Ongoing communication with HR is occurring to address vacancies and steps ADMH/DD may take to reach a broader audience with job announcements and recruiting opportunities.

Enrollment Challenges: Eligibility Documentation

CWP enrollments continue to lag behind set targets. The majority of the delays were the result of outdated or missing eligibility documentation. Many of the individuals interested in enrolling in CWP required an updated ICAP, and others needed a Medicaid eligibility determination. Many of the 310 agencies within the eleven CWP counties are struggling to recruit and employ staff, resulting in the inability to update eligibility documents in a timely manner.

Due to the 310 agencies' challenges, ADMH/DD Support Coordinators completed the needed eligibility updates and provided updates to individuals and families. With ADMH/DD Support Coordinators taking a direct role in updating eligibility, a significant increase in enrollments occurred in Q3, and this continued into Q4. This strategy resulted in 58 enrollments in one month, a pace that would have equated to facilitating 638 enrollments in the first demonstration

year – more than enough to fill the initial 500 slots available. The State is continuing to monitor the ability of the 310 agencies to complete necessary eligibility and updates for enrollment into the CWP. Some efforts were made at the Commissioner's level to provide additional funding to the 310 agencies for intake and eligibility work. A decision will be made early in year two whether the 310 agencies will be equipped to handle eligibility or if ADMH/DD will expand its workforce to assume this role.

To further address enrollment issues, the following steps were also taken:

- 310 agencies in CWP counties received training on their role in September of 2022.
- Eligible 310 agencies will receive a contract for intake and eligibility functions from ADMH/DD and now will be paid for this work.
- ADMH/DD Support Coordination staff will be able to assist as time allows, particularly where slow enrollments continue to be an issue.
- Call Center staff also received refresher training on CWP in September of 2022.

Additionally, regional ADMH/DD staff will continue to provide more hands-on oversight of the eligibility process going forward to help eliminate the delays that have occurred previously due to outdated eligibility documents.

Enrollment Challenges: 1115 Demonstration Group (Group 5)

During year one, there were no individuals enrolled into Group 5. ADMH/DD recognizes community education and promotion of the Group 5 option will need to be increased in the next demonstration year. This will include more communication with ADMH/DD's Call Center, 310 agencies in the CWP counties, and strategic outreach and marketing efforts. One outreach effort will include regional CWP staff linking potential enrollees with the state's Project SEARCH programs, in which high school youth with Intellectual/Development Disabilities (I/DD) participate in internships to gain marketable job skills and employment. Further, ADMH/DD employs six (6) Community Work Incentive Coordinators/Benefits Planners (CWICs) who meet on a regular and ongoing basis with referrals who receive Social Security benefits and have an interest in working. These CWICs will be able to promote the CWP as well as share information regarding Group 5 enrollments. Many times, CWICs meet with families and individuals who are not familiar with ADMH/DD waiver services. Finally, CWP leadership and consultants will review current eligibility criteria for this enrollment group and consider an amendment to expand the current eligibility criteria, particularly the ICAP scoring criteria. The criteria, which is only slightly different from the criteria used for the 1915(c) enrollment groups, is likely to be limiting how many people with I/DD are eligible to enroll. This explains the lack of enrollments in this group during the first year of the demonstration.

Provider Claims Approvals and Timely Provider Payments for Services Rendered

In demonstration year one, challenges persisted throughout the year related to denials of claims from CWP provider agencies due to third party liability (TPL) edits in Medicaid's claims billing system. TPLs are additional insurances that are billed primarily before Medicaid is considered the responsible funding source. When an individual has a TPL guarantor, the system flags the case for provider edits and rejects the billing. These provider edits and issues regarding lack of dedicated CWP billing codes for some services within the Medicaid system delayed payments to providers for many CWP services during the first demonstration year. ADMH/DD informed AMA of these issues, and corrective action is still being researched as of the end of demonstration year one. Once the appropriate corrective action(s) are identified by the Medicaid billing system, providers will begin receiving payment for services rendered. However, this problem has created considerable challenges for providers and increased provider reluctance to accept additional CWP referrals for services.

Appropriate Program Capacity and Expertise to Respond to Verified Emergency Referrals

In the first demonstration year, there were emergency referrals, verified to be bona fide emergencies, for which ADMH/DD and the CWP lacked appropriate capacity and expertise to respond timely and effectively. It is worth noting this was also an issue for the ADMH/DD legacy waivers during the demonstration year period.

With the CWP provider network in development during the year, there was a lack of providers to meet the needs being presented. Also, there were issues with staffing the needs of services once a provider accepted a person's request.

Having little to no providers to meet the needs of a person's emergency request required the implementation of emergency preventive methods. In cases where individuals in crisis needed positive behavioral supports and/or development of their agency's crisis continuum, CWP leadership provided assistance from one of its consultant agencies, Benchmark, through its ADMH/DD Comprehensive Supportive Service team. Benchmark was able to provide the following resources:

- Assistance with development of crisis continuum systems and services.
- Quality management and regulatory compliance consulting for I/DD/Medicaid residential providers.
- Consultation with state and funding agencies to develop services for intensive needs populations.
- Specialties around developing autism/Applied Behavior Analysis (ABA) programs.
- Building the following provider capacity:
    - Community-based nursing for clinicians.
    - Behavioral intervention skills for DSPs.
    - Institutional transitions / meaningful days.
    - Environmental structuring.

As part of a comprehensive solution, in year one of the demonstration, ADMH/DD hosted representatives from Project Transition, a long-term behavioral health support and services model for individuals who have a history of serious mental illness (including dual diagnosis) that desire living a meaningful life in their communities. Project Transition was contacted as a result of the ongoing need for resources to address large numbers of emergency referrals for ADMH/DD waiver services that typically end up in long-term hospitalizations after going through emergency departments.

Project Transition was established in 1982 and works exclusively with adults (including young adults approaching their 18th birthday) who struggle with serious mental illness, co-occurring substance use disorder and/or a Dual Diagnosis of I/DD and Behavioral Health challenges. Project Transition was founded on the fundamental belief that these individuals can and will thrive in the community if properly and energetically supported. All psychiatric rehabilitation services are delivered by coordinated teams of mental health treatment, substance use disorder, and I/DD professionals. ADMH/DD plans to move forward with finalizing its partnership with Project Transition during the first quarter of FY23.

Additionally, ADMH/DD is developing the capacity to enter into Memorandums of Agreement (MOAs) with other agencies involved in emergency referrals. The first MOA to address emergencies cases was established with the DHR. The agreement fostered the opportunity to recognize the need to provide coordinated, specialized services to meet the needs of individuals in DHR custody with developmental disabilities who met eligibility criteria for waiver services. The MOA afforded an individual the opportunity to receive the best possible services in the most appropriate/least restrictive setting and environment in the community, maintaining family engagement and connections. The MOA also included the development of an Individualized Service Plan (ISP) to be implemented by DHR for the benefit of the individual's legal guardian.

In focusing on preventing emergencies, ADMH/DD is engaging with START with the University of New Hampshire. START stands for Systemic, Therapeutic, Assessment, Resources, and Treatment, and this provider accreditation is one of the Preferred Provider Qualifications (PPQs) established for the CWP. The START Model was developed and implemented in 1988 by Dr. Joan B. Beasley and her team to provide community-based crisis intervention for individuals with I/DD and mental health needs. The model is evidence-informed and utilizes a national database. It is a person-centered, solutions-focused approach that employs positive psychology and other evidence-based practices. While the State can better address prevention of emergencies and assist providers to increase their PPQ scores by partnering with START, initial conversations have led to the need for a statewide needs assessment to be conducted by START.

Other Key Challenges, Underlying Causes, and Strategies Implemented to Address these Challenges

Support Coordination Staffing Challenges, Underlying Causes, and Strategies to Address Challenges

Support Coordination Capacity

While there were many successes throughout the year, the CWP experienced ongoing workforce issues, both with internal and external staff. ADMH/DD was unable to sustain a full support coordination workforce. As staff were hired, other staff vacated positions. The 310 support coordination agencies providing services in Region II of the Demonstration (Ability Alliance and Tri County Aid) also experienced ongoing staffing challenges. Below is the Annual Data for the Community Waiver Program Support Coordination. Region II is broken down to identify the external 310 agencies, Ability Alliance in Tuscaloosa County and Tri County Aid in Walker County. There was a total of eight (8) resignations, seven (7) new hires, and nine (9) remaining vacancies across all five regions.

Region	Resignations	New Hires	Remaining Vacancies
1	1	0	1
Tuscaloosa 2	1	1	1 Full Time 2 Part Time
Walker 2	1	1	0
3	1	2	0
4	1	1	2
5	3	2	3

Strategies to address challenges that were implemented during demonstration year one included:

- Implementation of monthly unit and rate.
- 30% enhancement payments made to Region 2 contracted Support Coordination providers (using state funds) for CWP Support Coordination services provided.

ADMH/DD is also planning to implement several strategies in demonstration year two to further address the roots of these challenges. Current ADMH/DD human resource (HR) classifications currently used for CWP Support Coordinators were originally established for agency administrative work in both the central office and the agency's five (5) regional offices. There are no existing classifications for support coordination staff in the ADMH/DD HR system. Therefore, CWP leadership will work with the agency's HR Division to establish a new classification for support coordination. By establishing the new classification, ADMH/DD can change minimum qualifications for these positions. Current entry level support coordination positions require both a degree and a minimum of two years of experience. This limits the pool of applications for support coordination. The ADMH Commissioner has already met with the CWP Director and approved for the CWP to move forward with establishing the following new classifications:

- Support Coordinator Trainee: Bachelor's Degree – no required work experience but must complete the internal training curriculum for Support Coordinators.
- Support Coordinator: Bachelor's degree with work experience and completion of the internal training curriculum for Support Coordinators.
- Support Coordinator Senior: Promotional opportunity for Support Coordinators who desire supervisory work or external candidates with appropriate education and experience.

Provider Network Challenges, Underlying Causes, and Strategies to Address Challenges

During the entire first demonstration year, providers reported ongoing challenges with providing CWP services due to the COVID-19 pandemic's impact on recruitment and retention of direct support professionals (DSPs). While recruitment and retention of DSPs was a serious issue even prior to the pandemic, it is now recognized to be a crisis threatening the stability of HCBS programs nationally. Recent research completed in 2021 by the American Network of Community Options and Resources (ANCOR) found that the COVID-19 pandemic further negatively impacted the direct care workforce that was already in crisis. This has been no different in Alabama. ANCOR credited sluggish reimbursement rates for services and provider agencies' inability to compete with other industries seeking similarly qualified and experienced workers for originally creating the workforce crisis. In February 2020, ANCOR conducted a survey of providers of community based I/DD services to glean a deeper understanding of how they experience the human and financial impacts of the DSP workforce crisis. The results of that survey revealed that, at alarming rates, providers were

discontinuing services, turning away new referrals, delaying the launch of new programs, and struggling to adhere to quality standards.
With the onset of COVID-19 and throughout the entire duration of the pandemic to date, the DSP shortage has been exacerbated by new pressures of the job and hazards of providing essential, close-contact services. While most states, including Alabama, provided record increases in reimbursements rates for services during the pandemic and allowed providers to pay sign-on bonuses, retention bonuses and hazard pay, providers have found this insufficient to compete with the increased rates of pay and benefits offered by other industries in the face of the widespread worker shortages impacting almost all industries.

Specifically, the research conducted by ANCOR found nationally:[7]

1. 84% of providers are delaying the launch of new programs and services.
2. 77% of providers are turning away new referrals.
3. 58% of providers are discontinuing programs and services.
4. 81% of providers are struggling to achieve quality standards.
5. 40% of providers are seeing higher frequencies of reportable incidents.
6. 92% of providers continue to grapple with the impact of the pandemic on recruitment and retention.

The findings of the research described above are consistent with the experiences in Alabama. The inability to recruit enough workers puts increased stress on existing staff, causing turnover of those staff and further exacerbating the shortage of workers. Simultaneously, providers are largely competing for the same limited pool of workers seeking employment. While many assume the solution to inadequate provider network capacity is to simply add more providers to the network, the real issue is the shortage of DSPs. Adding more providers to the network is likely to inadvertently disadvantage existing providers by creating a larger pool of provider agencies competing for the same limited pool of job seekers. According to the Department of Labor's September 2022 workforce data, the number of workers in the United States fell by 400,000 since March 2022. The total labor force is now about 600,000 workers less than it was in early 2020, just before widespread COVID-19 restrictions caused an economic recession.

The ANCOR study highlights how the direct service workforce crisis is likely to have negative consequences for the launch of new HCBS programs and/or the expansion of the number of people served in HCBS programs. States trying to start new HCBS programs and reduce their waiting lists are severely challenged by the direct service workforce crisis. As the ANCOR study demonstrates, and as is evident in Alabama, providers are being forced to decline or delay acceptance of new referrals due to an obligation to first ensure adequate staffing for the individuals they are already serving. Where providers are heavily invested in services that are very staff-intensive (e.g., 24/7 residential models), they struggle to accept and serve new referrals. Furthermore, those providers who have not implemented technologies to reduce their DSP support needs are even more disadvantaged.

Further exacerbating these challenges, providers are also reporting competition from other industries offering starting employee pay that they cannot match. In North Alabama, providers are competing against several large companies paying higher starting salaries for entry level positions, as compared to the rest of the state. Nationally and within Alabama, the debate continues over what should be considered an adequate DSP hourly wage and what reimbursement rate for each type of HCBS service is necessary to assure an adequate DSP hourly wage. In September 2022, the Alabama Service Providers Association (ASPA) suggested a $14/hour minimum DSP hourly wage.[8] Previous data collection shows that providers pay different hourly wages to DSPs, even though they are receiving the same reimbursement rates for the services these DSPs are providing. While there are a variety of explanations for this, the fact remains the correlation between certain reimbursement rates and certain minimum DSP hourly wages is not consistent or able to be assured. Providers utilizing DSPs across service types and programs might hire the DSP at the lowest hourly rate to ensure covering their costs, regardless of what service the DSP is providing. Consequently, providers may start new DSPs at lower wages than what reimbursement rates support so that providers can give raises to DSPs over time. Ultimately, this impacts the providers' ability to recruit new workers.

[7] This research on the current DSP shortage and crisis shared above can be found at https://www.ancor.org/wp-content/uploads/2022/08/the_state_of_americas_direct_support_workforce_crisis_2021.pdf.lity
[8] Ferguson, DeAnna. Presentation entitled "Budget Priorities" to ADMH/DD Subcommittee Workgroup; October 2022.

As reported by the CWP provider network, the shortage of DSPs was the primary reason that many providers agencies limited their acceptance of new referrals and ability to initiate service delivery throughout this year. While the program was successful in meeting minimum provider network requirements by region, as specified in the CWP approval, contracted providers were not always available to accept referrals for services due to their workforce shortages. More information on provider referral acceptance and timely service initiation can be found in the STC 30 section of this report.

Regular CWP provider meetings are held with providers on the 3rd Thursday of each month to address ongoing concerns with staff shortages and other issues for CWP providers. Thirteen (13) meetings were scheduled in year one of the demonstration, with ten (10) of these meetings held as planned. Following these regular meetings, additional information is distributed to the provider agencies by the Provider Network Manager, who also produces and distributes "Provider Notes" newsletters with regular updates for providers in the CWP network. A total of fourteen (14) newsletters were sent out to the provider network in the first year of the demonstration.

During the first demonstration year, ADMH/DD took the following steps to help alleviate the workforce crisis facing CWP providers:

- Distributed $2,495,573.88 in start-up funding for fourteen (14) newly selected CWP providers, allowing for the provision of sign-on, retention, and referral bonuses for newly hired staff for the CWP.
- Made enhancement payments of 30% to providers using state funds for all CWP services provided.
- Distributed $44,435.57 in funding to providers to cover the cost of training time for direct service professionals that were being hired and trained to deliver CWP services.
- Provided a competency-based online, on-demand, training course for direct service professionals working in the CWP free-of-charge for providers. Training content was developed by national experts. ADMH/DD allowed for portability of the credential earned.
- Eliminated duplication of training requirements by issuing policy guidance allowing DSPs who have completed the required training for CWP to be considered trained for providing services in the legacy ID and LAH waivers.
- Modified the amount of training a DSP must complete in order to begin providing some CWP services, moving completion deadlines for some required trainings to after the DSP begins providing CWP service.
- Provided, free-of-charge for providers, a competency-based online on-demand training course for provider agency supervisors/trainers of DSPs to become credentialed "Success Coaches" in order to support DSPs to successfully complete their training. Research on utilization of the "Success Coach" model has demonstrated success coaching can positively impact learner achievement in terms of learner persistence, learner retention, and learner completion.[9]
- Provided, free-of-charge for providers, third-party Success Coaches when providers did not have internal staff available to act in this role.

To address providers' capacity challenges to accept new referrals but not respond timely to referral requests, the Planning and Quality Assurance (P&Q) Specialist will be engaging with these providers and offering technical assistance. During the first year of the demonstration, the QE team completed the development of a corrective action assessment tool for non-responding providers. The tool is being used for technical assistance to support providers with overcoming barriers that prevent them from responding to CWP referrals and delivering services to waiver participants. If a corrective action plan is needed, the P&Q Specialist will initiate the development of the plan with the provider and follow-up to ensure compliance with the corrective action plan as well as all provider contract requirements. ADMH/DD is anticipating this, along with continuing all the above strategies, will steadily increase the referral acceptance rate by contracted CWP providers.

ADMH/DD is also planning a waiver amendment in demonstration year two to increase expenditure caps for all enrollment groups to make permanent the rate enhancements that were paid to providers during this first demonstration year. Also, ADMH/DD contracted with an external consultant during the demonstration year to study the current rates in all three waivers and to provide recommendations for rate adjustments going forward. Following a

[9] See https://www.watermarkinsights.com/resources/blog/the-outcomes-of-success-coaching retrieved 11/23/22.

public comments period, ADMH/DD is expected to make rate adjustments based on the results of the study as well as the input received from public comments.

Key Achievements and the Conditions or Efforts to which these Achievements are Attributed

Ensuring Fully Trained Direct Support Professional Workforce for the CWP

ADMH/DD continues to contract with the Quality Improvement in Long Term Services and Support (QuILTSS) Institute to provide the competency-based Alabama Employment and Community First (AL ECF) online training platform for DSPs. DSPs must complete the first sixteen (16) hours of training before they can begin supporting individuals in the CWP. Over two hundred (200) DSPs are currently enrolled in the course. Forty-six (46) DSPs have completed the entire forty-four (44) hour course, as of the last day of Q4. Success Coaches are embedded within the agencies to provide coaching and assistance to DSPs as they complete the AL ECF course. There are currently thirteen (13) Success Coaches embedded in provider agencies, each of which have completed a specially designed Success Coach curriculum also housed on the QuILTSS platform. Thirty-two (32) provider staff are currently enrolled in the Success Coach course.

ADMH/DD has also seen a steady increase in DSPs who have completed specialized trainings coordinated through The Columbus Organization or by ADMH/DD and ADRS, as outlined below:

Community Integration Connections and Skills Training Service: 28
Family Empowerment and Systems Navigation Counseling Service: 24
Financial Literacy: 17
Housing Counseling: 25
Independent Living Skills Training: 26
Peer Specialist: 24

As of the end of the first demonstration year (September 30th, 2022), thirty-three (33) DSPs in CWP provider agencies are certified as Job Coaches, while forty-six (46) are certified as Job Developers. Twenty-four (24) individuals have completed the Peer Specialist Services training.

The CWP will have two additional trainings, Community Integration Connections/Skills and Infection Control, on the QuILTSS Learning Management System (LMS) platform in the next quarter. This will allow providers to have access to these trainings 24/7 online.

Ensuring Quality in Provider Credentialing through a Collaborative Partnership with The Council on Quality Leadership

On October 5, 2021, the CWP began collaborative work with The Council on Quality and Leadership (CQL) to develop a multi-faceted quality management strategy to satisfy Division standards, measure provider performance, and ensure that services adequately address the needs of individuals supported. Within the first quarter, the team partnered to formulate Credentialing Visit Workbooks (Excel format) that would include the following basic tenets:

1) a hybrid of virtual and on-site activities
2) opportunities for direct feedback from those receiving services and, as applicable, their families
3) inclusion of provider practices as well as policies and procedures
4) a technologically practical assessment process
5) ongoing discussion, technical assistance, and provider support.

The team reviewed the Alabama Administrative Code 580-3-23 Certification for Community Programs and the ADMH/DD Provider Operational Guideline Manual (published 05/31/21) to identify standard compliance procedures. Additionally, the CWP and CQL team utilized the HCBS-Act Project and Tennessee's Employment and Community First (ECF) documents to establish an effective and measurable community-based service performance framework. As a result, the team identified the following six broad focus areas for certification concentration: staffing, person-centered

planning and service provision, communication, values, and recordkeeping. Finally, CWP and CQL created a shared Microsoft Teams' platform to encourage ongoing collaborative communication.

The CWP and CQL team introduced the Alabama CWP Certification Framework, later renamed the CWP Credentialing Framework, at the beginning of the second demonstration quarter. The Excel workbook templates within the Excel tool included the identified six focus areas, and each workbook had a general visit sheet as well as an individual sheet for each of the 33 CWP services. Using the CWP Scopes of Services, the team began to extract performance and quality indicators and identify needed evidence to substantiate these indicators. The team also developed the first draft of the conversation guides/prompts for interviews and the CWP Credentialing Operational Guide. Collaboratively, the team identified possible implementation issues with the current framework. Expressed concerns were:

- The limited number of Planning and Quality staff available to assess each CWP provider.
- The frequency and length of contact time required with each provider.
- The minimal flexibility of Planning and Quality staff to offer technical assistance as needed.

As a result, the critical focus areas became staff quality and continuity, communication, values, and administrative functions. Workbooks were simplified to include drop-down tabs for selecting services provided, performance indicators, and activity tags. The team filtered services for alternate credentialing review. Furthermore, the team completed and developed a draft of focus group questions and a person-served satisfaction survey. Quality Enhancement staff will utilize the person-served interview to determine the overall satisfaction of the CWP participants receiving services.

In the third quarter of reporting, CQL and CWP completed the draft version of the excel workbooks for all focus areas. QE staff will record information directly into the approved workbooks based on information received from the provider's administrative and direct service staff, along with people served and their family members. QE staff will collect this information during monthly visits, either on-site or virtually, using targeted conversations, focus groups, and documentation reviews. The planned structure of monthly visits is the most notable aspect of CWP credentialing that differentiates it from "traditional certification" in the existing ID and LAH waivers operated by ADMH/DD.

The Scopes of Services was revised to ensure that the workbooks included all performance indicators. The team meticulously reviewed performance measurement indicators and removed any items that were either instructive or relevant to specific time points in the service delivery process. The team also reviewed the most recent version of the comprehensive operational guideline, which covered the provider recruitment process, the initial Temporary Operating Authority (TOA) process, the initial annual credentialing process, and the ongoing re-credentialing process.[10] Comments concerning the guideline, particularly the provider's right to appeal a decision, were discussed and revised for clarity.

CQL assisted with developing templates to improve communication with providers regarding upcoming visits. Email templates were completed and uploaded to the Microsoft Teams site. In addition, the team discussed ways to create a shared Microsoft Teams channel for each provider. The group believed the Microsoft Teams platform would enhance transparency and compliance with the organizational guideline.

In the final quarter of the demonstration year, QE staff worked with CQL to edit, finalize, and submit the credentialing tools to AMA for approval.

Quality Enhancement staff and CQL introduced providers to the CWP Credentialing process. CQL offered two instructional sessions on the navigation of the credentialing workbooks. Furthermore, video demonstrations, PowerPoint presentations, and documents were uploaded to the Microsoft Teams site for provider reviews.

QE staff organized provider reports outlining when they began delivering services (participant start dates), provider locations, and non-responding providers. Quality Enhancement staff developed Microsoft Teams channel sites for active providers and assigned provider sites to QE team members.

[10] Once a provider's application is approved for a new setting or new service, the program is issued a letter of Temporary Operating Authority (TOA) by the DMH/DD Commissioner allowing it to operate for a period of up to 6 months.

In September 2022, the Quality Enhancement team began meeting with providers to implement the credentialing process using the approved credentialing tool. QE staff visited the following agencies to start the process: The Arc of Madison County (Region 1), Rainbow 66 (Region 4), and VOA (Region 3). Providers responded favorably to the tool regarding the ease and transparency of the credentialing process, the usefulness of the credentialing workbooks, and the open communication and technical support provided by QE staff.

Providers also shared a list of concerns with QE staff during their initial credentialing process. These concerns included:

1. Provider agencies, particularly smaller agencies, reported a delay in receipt of start-up funding available to cover the expenses incurred for service implementation. The significant expense identified was the paid time required for direct service staff to complete required training. Smaller provider agencies experienced this financial strain in a more pronounced way because they typically have fewer financial reserves available. The Network Provider Manager advised providers of the process for acquiring the funding and the documentation requirements to ensure reimbursement for training expenditures.
2. Technology barriers for some DSPs to complete online training were an additional concern. Providers indicated that the QuiLTTS platform did not allow for modified training options for potential employees with limited or no technology experience. While the provider may identify possible personnel who demonstrate superior characteristics for being great employees, those with inadequate computer skills would terminate the process before completion. Quality Enhancement staff suggested pairing the potential employee with a mentor who could assist them through the process. However, provider agencies were reluctant to pursue this approach due to staffing shortages and limited funding.
3. Providers state that there is an overall ease of training for DSPs under the ID and LAH waivers compared to the intensive QuiLTTS training required for CWP. While all waivers have similar expectations in training, providers believe that ID and LAH waivers provide flexibility in the type of platform used, the method of how the material is presented, and the pace of the training. However, Quality Enhancement staff reminded providers that completion of CWP training also qualifies employees to provide ID and LAH services, creating the value of cross-trained staff.
4. Multiple providers expressed issues with responsiveness from QuiLTTS representatives when attempting to advance DSPs trained through the training process. The QuiLTTS program relies heavily on using "success coaches" to ensure the learner's understanding of the material presented. Providers indicated that they often wait for approval from the success coaches to move forward in the program, which halts progress. If the provider has an internal certified success coach, issues with the QuiLTTS program often need to be answered or may take several weeks for resolution. The CWP program continues to collaborate closely with the QuiLTSS. According to the QuiLTTS representative, the learner is often required to complete additional steps but fails to follow through. To address the responsiveness issue, CWP staff has requested that QuiLTTS provide weekly updates and report learners' progress in the program.
5. The seven-day request for providers to serve a person enrolled in the waiver created challenges for providers due to the need for a better understanding of DSP pre-service training requirements. It was also an incorrect belief that if a provider accepted an RFP, the provider must initiate services immediately rather than within the allowable timeframes set by the program. Quality Enhancement reviewed the training guidelines with providers and instructed them on the RFP process. QE also directed providers to the ADMH/DD CWP website, where vital information, such as the Scopes of Services, training requirements for providers, and CWP Waiver Service rates are located.
6. Once an RFP was accepted, providers indicated challenges with staffing due to the limited number of authorized units. To clarify, once an employee has completed the necessary training for CWP, the employee often needs more hours to maintain employment. For example, an individual supported may receive 8 hours of Personal Assistance-Home per week. If an employee is seeking a full-time job, more than 8 hours per week is needed. Quality Enhancement staff informed providers that a CWP-trained employee is certified to provide services under the LAH and ID waivers. Therefore, it is acceptable to utilize trained employees in other programs to accommodate work hours.
7. Providers expressed challenging working relationships with Support Coordinators unfamiliar with Medicaid Waiver Services. Some of these concerns could be the result of Person-Centered Planning no longer being a role for provider agencies, where they may have influenced PCP services previously. As a result, some providers believe that Support Coordinators often authorize inappropriate services for individuals. Providers have stated

that they have had to withdraw a service after determining that the individual's desired outcome did not correspond with the authorized service. To address this reported deficit, Teresa Brazile, Director of Support Coordination, provides service coordinators and supervisors monthly training on services and supports for individuals served.

8. Providers also disclosed dissatisfaction with the lower reimbursement rates, particularly for stand-alone Community Transportation services. Currently, the Community Transportation - Agency Paid Driver (No Residential Service) rate is $1.00 per mile and is limited to 250 miles per month, according to Scopes of Service. Providers indicate that the mileage caps create deficits for the agency if they are required to supplement any mileage above 250 miles to accommodate individuals who live greater distances in the county. ADMH/DD Fiscal Operations are continually reviewing the agency's reimbursement rates and are presently conducting rate comparison studies.

Information Technology System

Therap Incident Prevention and Management System (IPMS)

The process of launching the Therap CWP Incident Prevention and Management System (IPMS) was initiated in Q3. The ADMH/DD Call Center was identified as the point of entry of enrollments for CWP into the Therap Electronic Record System. The CWP Support Coordinator Supervisor is responsible for providing the Call Center staff with the following enrollment information:

i. Enrollee First Name
ii. Enrollee Last Name
iii. Enrollee Middle Initial (if applicable)
iv. Date of Birth
v. Medicaid Number
vi. ADIDIS Case Number
vii. List of all Providers servicing the enrollee
viii. Identify Region of Service

The Call Center staff enrolls people into the Therap system under the appropriate provider(s) from which the person is receiving services. Also, each person is added to the Regional IPMS caseload by the Call Center. CWP Leadership and Therap conducted training for both the CWP Provider Network and CWP Support Coordinators in Q4, and the system launched in Q4.

As of the end of the first demonstration year, with the launch of the IPMS system during the fourth quarter, there were no incidents reported in the Therap. Moving forward, incident data will be reviewed and analyzed consistent with the *ADMH Incident Prevention and Management System Manual (July 2022)* requirements. This includes weekly, monthly, and quarterly Incident Review Committee meetings and reports from the Office of Quality Assurance used to make recommendations for systematic intervention and improvements to the quality of services.

Administrative Code

After CMS's approval of the CWP, ADMH/DD amended Chapter 580-5-30 of the Administrative Code, Intellectual Disabilities Services, to authorize and support Alabama's new CWP. The amendment also strengthened language necessary to comply with the federally mandated HCBS Settings Rule governing all Waiver programs administered by ADMH/DD. The amendment was published November 30, 2021, in the Alabama Administrative monthly, Volume XL, Issue No.2. The comment period extended into Q2 and ended on January 4, 2022. The proposed Administrative Code revisions were codified, and final adoption commenced on May 15, 2022.

Provider Network Successes

The CWP will have two additional trainings, Community Integration Connections/Skills and Infection Control, on the QuILTSS LMS platform in the next quarter after working to get this platform developed during quarter four. This will allow providers to have access to these trainings 24/7 online.

The Provider Network has continued to expand. The network has grown from an initial 13 providers to 33 as of the end of demonstration year one.

Staff within the provider agencies continue to work towards completing the necessary credentialing to deliver CWP services. Currently, 46 have completed the Alabama Employment and Community First (AL ECF) QuILTSS, and 27 are in progress, many having completed 16 hours or more. Also, 13 individuals have completed the Alabama Employment and Community First Success Coach curriculum, and 32 are in process.

Establishment of Annual CWP All-Staff In-Person Meeting

A statewide CWP meeting brought together CWP staff to discuss first year challenges and successes, and to identify technical assistance and training needs going forward. The CWP consultant who was instrumental in the development and initiation of the CWP overall made a site visit during this time to facilitate the meeting, as well as participate in meetings with the provider network, stakeholders, and ADMH/DD leadership.

Identified Beneficiary Issues and Complaints

There was a total of one (1) complaint/grievance during the demonstration year. Therefore, no patterns or trends could be analyzed. The complaint resulted from a misunderstanding of options available under self-directed services. The complaint was quickly resolved, once correct information on self-direction options were shared with the CWP participant. Retraining of CWP Support Coordinators occurred soon after to ensure all Support Coordinators had a complete understanding of how self-direction works in the CWP.

Lawsuits and or Legal Actions

There were no lawsuits or legal actions related to the CWP for the first demonstration year.

Legislative Updates

House Bill (HB) 105, sponsored by Representative Gaston – *DHR Elder Abuse Registry (Act 2022-161*), received final passage in this year's legislative session. ADMH/DD is actively coordinating with DHR for the rollout and implementation of the statewide Elder Abuse Registry by the end of 2022, of which ADMH/DD Waiver Services programs and their staff, including those in the CWP, will be participating in beginning in 2023. The ADMH/DD is porting over information from Therap to DHR as required for implementation of Act 2022-161 for those individuals actively under Adult Protective Services (APS) investigation and/or with substantiated APS findings.

The new Elder Abuse Registry will provide *instant confirmation of an APS request*, which is a common request from providers to ensure CWP compliance. The "request" will be an online fillable PDF form on the DHR website. Providers can submit multiple requests for new hires all at once and receive an automatic email once the form is completed.

ADMH/DD participated in a demo of the Elder Abuse Registry on September 12, 2022. Housed at DHR, ADMH/DD, the Alabama Department of Corrections (ADOC), Alabama Department of Public Health (ADPH) and the Administrative Office of Courts (AOC) participate in this registry.

Unusual and Unanticipated Trends

There were no unusual or unanticipated trends during the first demonstration year.

STC 41: Performance Metrics

In Q1, the State established a set of key performance metrics aligned with the goals for the CWP. The performance metrics below are intended to provide data to demonstrate:

A. How the State is progressing towards meeting the demonstration's goals.
B. The effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured population.
C. Quality of care through beneficiary satisfaction surveys and grievances and appeals.

D. How the demonstration is ensuring HCBS Rule compliance and advancement of the Rule's underlying goals.

Additional metrics will be added to future monitoring reports, including metrics evaluating quality of care and cost of care, once sufficient enrollments are achieved to effectively implement these metrics. Below are the initial performance metrics the State established and where available, data is presented for the first demonstration year.

A. Data Demonstrating How the State is Progressing Toward Meeting the Demonstration's Goals

Program Goal #A1: Enroll five hundred (500) participants in first year of CWP.

Metric #1: Total enrollments as compared to total targeted enrollments for the reporting period

Numerator: Total enrollments for the reporting period.
Denominator: Total targeted enrollments for the reporting period.

Data Collection Methodologies: Enrollments are entered into the Alabama Department of Intellectual Disabilities Information System for Case Management and Claims Billing (ADIDIS), on the Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing enrollments during the reporting period is pulled from ADIDIS to obtain the numerator. The denominator is based on the table below illustrating the Anticipated Pace of Enrollments, which corresponds with each quarterly and the first annual STC reporting periods.

Anticipated Pace of Enrollments (Updated April 2022)	Total Targeted Enrollments Statewide (Not including reserve capacity)	% of Total Enrollments in Year 1 of CWP (Not including reserve capacity)
November-December 2021	35	8%
January-March 2022	24	5%
April-June 2022	184	42%
July-September 2022	200	45%
Total Slots (not including reserve capacity)	443	100%

Data for the Reporting Period:

Total Enrollments for the Reporting period	Total Targeted Enrollments	Performance
173	**443**	**39%**

Data Discussion:
Actual enrollments into the CWP did not meet the anticipated pace for targeted number of enrollments of 500 during the demonstration year. The State achieved 39% of the targeted number of enrollments. As noted in the discussion of challenges in a prior section of this report, the primary reason for this was the absence of up-to-date eligibility documentation, which is the responsibility of 310 Boards throughout the state. Also as noted in the discussion on outreach efforts at the beginning of this report, outreach has been very successful with individuals on the waiting list identified for most all of the non-reserve capacity slots.

Program Goal #A2: Support participation in competitive integrated employment by CWP participants

Metric #1: *Percentage of working-age CWP participants who enrolled with a goal to obtain or maintain competitive integrated employment*

Numerator: Total CWP enrollments, ages 14-64, with enrollment priority for obtaining or maintaining competitive integrated employment.

Denominator: Total CWP enrollments, ages 14-64, for the reporting period.

Data Collection Methodologies: When enrollments are entered by the Regional Office Wait List Coordinator, the ADIDIS "Demographics" screen is also filled in using data from CWP Waitlist Details Database, including the enrollment priority category. ADMH/DD is using this demographics screen data in ADIDIS for this metric, which tracks each CWP enrollee's Enrollment Priority Category selected from the following options:

1. Preserve existing living arrangement.
2. Obtain/maintain competitive integrated employment.
3. Preserve existing living arrangement AND obtain/maintain competitive integrated employment.

New enrollees during the reporting period, ages 14-64 and in categories two (2) and three (3), are counted in the numerator.

Enrollments are entered into the ADIDIS system's Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing all new enrollments, for individuals ages 14-64, during the reporting period is pulled from ADIDIS to obtain the denominator.

Data for the Reporting Period:

Total CWP enrollments, ages 14-64, with enrollment priority for obtaining or maintaining competitive integrated employment	Total CWP enrollments, ages 14-64, for the reporting period	Performance
90	**168**	**53.6%**

Data Discussion:
During the first demonstration year, over 50% of working-age enrollees expressed interest in obtaining and maintaining competitive integrated employment as a reason for their desire to enroll in the Community Waiver Program. This high percentage of enrollees identified a goal to obtain and/or maintain competitive integrated employment with supports from the CWP sets in place the strong likelihood that the CWP will achieve competitive integrated employment rates above the estimated national average.

Program Goal #A3: Keep families together and supporting independent living as the optimal community living options

Metric #1*: % of CWP participants that are living with family/natural supports or living in an independent living arrangement.*

Numerator: Total CWP participants as of the last day of the reporting period that are living with family or other natural supports or living in an independent living arrangement.

Denominator: Total CWP participants as of the last day of the reporting period.

Data Collection Methodologies:
Within the first thirty (30) days of enrollment, Support Coordinators are responsible for obtaining and entering correct information on "Residence Type" into ADIDIS "Demographics" screen for each CWP participant. A "Date Residence Type Updated" field is also required to confirm updating of the Residence Type field is occurring at regular intervals. On a quarterly basis, after initial enrollment, the Support Coordinator is required to collect and record updated information on Residence Type using the required "CWP Face-to-Face Visit Tool." The Support Coordinator is then required to use information collected to update the "Residence Type" and "Date Residence Type Updated" in the ADIDIS "Demographics" screen for each CWP participant. A report is pulled from ADIDIS as of the last day of the reporting period to determine how many CWP participants, as of the last day of the reporting period, have a residence type that indicates they are living with family/natural supports or living in an independent living arrangement. This number is the numerator. Data from the ADIDIS CWP Participant File is pulled, as of the last day of the reporting period, to obtain the denominator.

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period that are living with family or other natural supports or living in an independent living arrangement	Total CWP participants as of the last day of the reporting period	Performance
159	**173**	**92%**

Data Discussion:
In the first demonstration year, CWP enrollees that were seeking services to sustain their family/natural living arrangement continued to be high. Overall, as of the last day of the first demonstration year, 92% of CWP enrollees were being supported to sustain family/natural living arrangements or live independently. [11]

Program Goal #A4: Support use of self-direction by CWP participants

Metric #1: % of CWP participants who are opting to self-direct one (1) or more of their services.

Numerator: Total CWP participants as of the last day of the reporting period who have one (1) or more services in their Person-Centered Plans that can be self-directed and who are self-directing at least one (1) of those services.

Denominator: Total CWP participants as of the last day of the reporting period who have one (1) or more services in their Person-Centered Plans that can be self-directed.

Data Collection Methodologies: Regional Office Fiscal Managers enter service authorizations into ADIDIS from approved Person-Centered Plans for CWP participants, previously entered into ADIDIS by Support Coordinators. The denominator is generated by running a report from the ADIDIS CWP Participant File, as of the last day of the reporting period, to obtain the complete list of CWP participants. For this list of CWP participants, a service authorizations report is then run, as of the last day of the reporting period, for all CWP service types that can be self-directed. The total number of CWP participants with one (1) or more CWP service types that can be self-directed authorized, constitute the denominator.

For those CWP participants included in the denominator, a service authorizations report is run, as of the last day of the reporting period, for all CWP service codes that indicate self-directed services are authorized. All CWP participants included in the denominator that have at least one (1) self-directed service code authorized, as of the last day of the reporting period, are counted in the numerator.

[11] Includes individuals, age 18+, able to live in a home or apartment, that is not provider owned or controlled, with Non-Intensive Supported Living Services and/or Remote Supports.

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period who have one or more services in their Person-Centered Plans that can be self-directed and who are self-directing at least one of those services	Total CWP participants as of the last day of the reporting period who have one or more services in their Person-Centered Plans that can be self-directed	Performance
26	91	28.6%

Data Discussion:
In demonstration year one, the impact of the range of services that can be self-directed combined with provider agencies facing a shortage of available direct support workers drove up self-direction participation rates to well above historical utilization in the legacy waivers, which stood at 10.4% in Q3 of the demonstration year. Nearly one in three CWP participants was using self-direction, as of the end of the demonstration year. CWP Support Coordinators continue to receive training on self-direction, so they are optimally prepared to explain and facilitate self-direction, and ADMH/DD has also increased its engagement with contracted FMSAs to ensure their readiness to serve CWP participants choosing to self-direct.

B. Data demonstrating the effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured population

Program Goal #B1: Increase access to Medicaid for uninsured individuals with intellectual disabilities

Metric #1: % of CWP participants enrolled during the reporting period who qualified for and/or first received Medicaid coverage as a result of CWP enrollment.

Numerator: Total CWP enrollees during the reporting period who initially qualified for and/or first received Medicaid coverage as a result of CWP enrollment.

Denominator: Total CWP enrollments during the reporting period.

Data Collection Methodologies: Enrollments are entered into the ADIDIS Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing enrollments during the reporting period is pulled from ADIDIS to obtain the denominator.

Data for the Reporting Period:

Total CWP enrollees during the reporting period who qualified for and/or first received Medicaid coverage as a result of CWP enrollment	Total CWP enrollments during the reporting period	Performance
6	173	3.5%

Data Discussion:
Because outreach to individuals with intellectual disabilities eligible for 1115 Group 5 started during Q2 and as noted in the Challenges section of this report, the outreach strategies have not been as effective as anticipated, all individuals

targeted for enrollment in year one were still being pulled from the existing waiting list. They are pulled from the waiting list based in part on length of time waiting, and most typically already have Medicaid eligibility. There were only six (6) enrollments into the CWP during the demonstration year who did not already have Medicaid eligibility through another source. These six (6) enrollments represent the total number of enrollments that needed 204/205 and 376 forms to enroll.

It should be noted that data from the previous reports indicate a total of four. However, a review of the data notes the correct numbers are as follows. There was one enrollee in Q1, three enrollees in Q2, two enrollees in Q3, and zero enrollees in Q4.

C. Data demonstrating quality of care

Program Goal #C1: Ensure high CWP participant satisfaction

Metric #1: % of CWP participants surveyed during quality monitoring activities conducted during the reporting period who have measured satisfaction with the CWP that is at least 85%.

Numerator: Total number of CWP participants surveyed during quality monitoring activities conducted during the reporting period whose measured satisfaction with the CWP is at least 85%.

Denominator: Total number of CWP participants surveyed during quality monitoring activities conducted during the reporting period.

Data Collection Methodologies: Data is pulled from "CWP Participant Satisfaction Survey" database in which CWP Quality Monitoring staff enter the date and results of each CWP Participant Satisfaction Survey conducted during the reporting period as part of provider re-credentialing processes. A report is pulled after the end of each reporting period that contains information on the total number of CWP Participant Satisfaction Surveys completed during the reporting period. This number is the denominator.

When the Quality Monitoring staff enter the results for each CWP Participant Satisfaction Survey conducted during the reporting period, the entries result in a calculated satisfaction percentage. Among all CWP Participant Satisfaction Surveys completed during the reporting period, every survey with a calculated satisfaction percentage of 85% or higher is counted in the numerator.

Data for the Reporting Period:

Total CWP participants surveyed during quality monitoring activities conducted during the reporting period whose measured satisfaction with the CWP is at least 85%	Total CWP participants surveyed during quality monitoring activities conducted during the reporting period	Performance
N/A	N/A	N/A

Data Discussion:
The CWP Participant Satisfaction Survey is being implemented as part of provider re-credentialing visits in year two of the demonstration. This re-credentialing process commences within six (6) months after a provider begins to deliver services to at least one individual referred through the CWP and includes a series of visits throughout the year focused on different topical areas for recredentialing. Due to this reporting period being for the first year of the program, this re-credentialing process had begun in year one; but no providers had received the specific visit that included use of the Participant Satisfaction Survey tool. ADMH/DD anticipates being able to report data on this metric in the year two monitoring reports.

Metric #2: % of CWP participants filing a grievance and/or appeal during the reporting period.

Numerator: Total CWP participants filing a grievance and/or appeal during the reporting period.

Denominator: Total CWP participants as of the last day of the reporting period.

Data Collection Methodologies: Data on all filed grievances and appeals is documented in the ADMH/DD Office of Appeals and Constituency Affairs' grievance and appeals database, which will be used to pull the number of newly filed grievances and appeals during the reporting period.

Data from the ADIDIS CWP Participant File is pulled, as of the last day of the reporting period, to obtain the denominator.

Data for the Reporting Period:

Total CWP participants filing a grievance and/or appeal during the reporting period	Total CWP participants as of the last day of the reporting period	Performance
1	173	<1%

Data Discussion:
There was a total of one (1) grievance during the demonstration year. Therefore, no patterns or trends could be noted. The compliant resulted from a misunderstanding of options available under self-directed services. The complaint was quickly resolved, once correct information on self-direction options were shared with the CWP participant. Retraining of CWP Support Coordinators occurred soon after to ensure all Support Coordinators had a complete understanding of how self-direction works in the CWP.

D. Data Demonstrating Results of Key Policies Adopted Under the Demonstration

Key Policy #D1: Utilize settings that conform to the greatest extent with the Medicaid Home and Community Based Services (HCBS) Settings Final Rule

Metric #1: % of CWP participants receiving all services in settings that are not provider owned or controlled.

Numerator: Total CWP participants as of the last day of the reporting period with approved (signed) Person-Centered Plans who are receiving all CWP services* in settings that are not provider owned or controlled.**

**All CWP services is defined as all CWP services on the Person-Centered Plan except:*

- *Occupational Therapy*
- *Physical Therapy*
- *Speech/Language Therapy*
- *Community Transportation*
- *Individual-Directed Goods and Services*

***Provider owned, or controlled settings are defined as specific, physical places, in which a CWP participant resides and/or receives CWP services, that are owned, co-owned, and/or operated by a provider of CWP services.*

Denominator: Total CWP participants as of the last day of the reporting period with approved Person-Centered Plans.

Data Collection Methodologies: Regional Office Fiscal Managers enter service authorizations into ADIDIS from approved Person-Centered Plans for CWP participants that have been entered into ADIDIS by Support Coordinators.

The denominator is generated by running a report from the ADIDIS CWP Participant File, as of the last day of the reporting period, to obtain the complete list of CWP participants. Then, using this list of CWP participants, a service authorizations report is run, as of the last day of the reporting period, to identify the sub-set that has services authorized indicating an approved (signed) Person-Centered Plan is in place. This generates the denominator.

For the numerator, a service authorization report will be run for each CWP participant included in the denominator. Authorizations for the following service types will be excluded:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Community Transportation
- Individual-Directed Goods and Services

Remaining authorizations for each CWP participant will be analyzed. A CWP participant will be counted in the numerator if none of the following authorizations appear in their remaining authorizations:

- Community-Based Residential Services
- Adult Family Home

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period with approved (signed) Person-Centered Plans who are receiving all CWP services* in settings that are not provider owned or controlled**	Total CWP participants as of the last day of the reporting period with approved (signed) Person-Centered Plans	Performance
104	**113**	**92%**

Data Discussion:
Of the 113 CWP participants as of the last day of the demonstration year who had a signed PCP including services in addition to Support Coordination, only nine (9) were receiving a CWP-funded service in a setting that is provider owned or controlled. These settings were exclusively residential settings. It should be noted that as of the last day of the demonstration year, there were a total of thirty-two (32) CWP enrollees that had been enrolled less than sixty (60) days and therefore would not be expected to have a signed PCP including services other than Support Coordination. Based on total enrollments as of the last day of the demonstration year, this leaves twenty-eight (28) participants who were enrolled more than sixty (60) days and therefore were expected to, but did not, have an approved Person-Centered Plan including services other than Support Coordination. This was due primarily to workforce shortages being experienced by providers, as previously discussed and documented.

STC 41: Budget Neutrality and Financial Reporting Requirements

There were no Group 5 individuals placed during the first demonstration year (fiscal year of 2022). The annual CWP-1115 Budget Neutrality Workbook has been sent to the AMA.

STC 48: Evaluation Activities and Interim Findings

See Appendix B.

STC 30: Preferred Provider Selection

Preferred Provider Network

Historically, ADMH/DD has managed an open provider network due to the State's obligation under federal law to contract with any willing provider for its 1915(c) legacy Waivers. Increasingly, the number of providers enrolled for a 1915(c) Waiver has outweighed the capacity needed to serve people, leaving all providers with fewer referrals than needed to operate effectively and efficiently. This has often resulted in high vacancy rates for Residential Habilitation in particular. Yet, the State has continued its obligation to enroll any new provider that wants to provide Residential Habilitation services. Further, the State is required to regularly monitor and certify each of these new providers and all of their HCBS settings, in addition to regularly monitoring and re-certifying all existing providers and settings. This has resulted in ADMH/DD staff resources for these tasks being stretched increasingly thin, allowing ADMH/DD staff minimal time to work with providers on quality improvement and innovation. Most of ADMH/DD staff time for managing the legacy Waiver provider network has consequently gone to addressing poor performing providers, leaving little to no time to work with better performing providers on quality improvement and innovation. Over time, this has created a natural tendency for ADMH/DD to establish more rules and restrictions on flexibility in response to the focus on poor performing providers.

Under the CWP 1115(a) demonstration Waiver approval, the State received federal authorization to limit the provider network based on need/capacity and provider performance. While ensuring choice of provider for the individual is paramount, a limited provider network can be critical for ensuring:

- The network is made up of only the highest performing providers.
- Providers can receive enough referrals to operate effectively and efficiently.
- ADMH/DD has sufficient capacity to work with the providers on quality improvement and innovation.
- The available Provider Readiness Initiative funding is sufficient to adequately invest in and support the full provider network.
- Unnecessary rules and limitations are not placed upon providers in ways that make it difficult for providers to deliver quality services.

The CWP utilizes a preferred provider network, which means providers must meet certain Preferred Provider Qualifications (PPQs) to be selected for enrollment. In addition to giving the State the ability to better ensure the provider network is the highest quality, as described above, this also allows the State to rebalance state resources to offer more quality-oriented training and technical assistance to providers, along with rightsizing and reorienting the provider network toward more collaborative State compliance monitoring processes. ADMH/DD maintains documentation of each provider's PPQ score and updates the score annually as part of re-credentialing.

The CWP preferred provider network must: (1) be recruited through an RFP process; (2) meet PPQs as set forth in the Waiver agreements governing the CWP; and (3) be selected based on RFP score, consistent with the standards, terms and conditions set forth in applicable Waiver agreements governing the CWP. Further, monitoring of provider network adequacy must be done in a systematic way, consistent with the standards, terms, and conditions set forth in applicable Waiver agreements governing the CWP.

The COVID-19 pandemic and direct service workforce shortage that has continued unabated since the pandemic creates a significant change of circumstances for the State to navigate, as discussed previously in this report. Ongoing work continued throughout demonstration year one focused on securing the necessary providers for all services in the CWP, as well as an appropriate number of providers in each of the eleven (11) counties based on anticipated enrollments. ADMH/DD is committed to maintaining an appropriate number of providers needed for each type of service offered in the CWP based on the geographic area and number of current and anticipated enrollments. ADMH/DD developed utilization methods for monitoring provider capacity as discussed below and required under the CWP Waiver approval.

Preferred Provider Qualifications for Current CWP Providers

The minimum PPQ score for a provider to be admitted to the CWP network, if selected through the RFP process, is twelve (12). However, ADMH/DD has been able to recruit and establish a provider network for the CWP that collectively achieved an average PPQ Score of twenty-four (24), with a range of scores from twelve (12) to forty-two (42). The re-credentialing process has an integral focus on assisting existing providers to increase their PPQ scores over time. *See Appendix A for Indicators on Preferred Provider Selection.*

Monitoring Provider Capacity

The State is monitoring provider capacity on a monthly and quarterly basis. The State is reporting its monitoring process and outcomes in this annual monitoring report per requirements of the approved CWP Waiver. The data utilized includes information for last six (6) months of Year one (Q3 and Q4) for the following reasons:

1. A standardized tool for CWP providers to report service initiation and projected future capacity to accept new referrals was developed and implemented for a portion of Q2. The tool was improved and implemented in Q3 and Q4. As a result, the methodology for monitoring provider capacity was applied in a way that produced more valid and reliable results in the second half of the first demonstration year. Therefore, for this first demonstration year, the annual data consists of Q3 and Q4 data. The complete methodology was applied to this data and is reported below.

2. During Q2 of the first demonstration year, fields were added to the ADIDIS case management information system to enable CWP SCs to track referrals to providers, including dates for referrals sent to, and accepted by, a provider. The design of these system changes created the potential for reporting of complete data required for the monitoring of provider capacity as defined in STC 30. Re-training of Support Coordinators has proven necessary to ensure correct use of these fields on a consistent basis. Data is reported for Q3 and Q4 below; but issues with correct and consistent use of these fields by Support Coordinators did create some incomplete data for year one of the demonstration which the state anticipates will not continue beyond year one.

Method Step #1:

By service and by region, the State will report any changes to the number of preferred providers.

At the end of the first demonstrate year, there were a total of thirty-three (33) providers collectively providing thirty-three (33) CWP services across the five (5) regions. This represents no change from the number of providers reported in Q3 of the first demonstration year. These providers include two (2) contracted providers of Support Coordination in Region 2. (Note: ADMH as a provider of Support Coordination for the CWP in Regions 1, 3, 4 and 5.)

Method Step #2:

By region, the State will assess existing providers prospective capacity to accept additional referrals for each service.

Existing CWP providers' reports on prospective capacity, as of the end of the first demonstration year, are summarized in the chart below:

CWP Service Type		Providers' Reported Capacity to Accept New Referrals As of Last Month of Demonstration Year one (September 2022)				
		REGION 1 TOTAL	REGION 2 TOTAL	REGION 3 TOTAL	REGION 4 TOTAL	REGION 5 TOTAL
Adult Family Home		3	**0**	2	1	**0**
Assistive Technology and Adaptive Aids		54	40	44	55	25
Breaks and Opportunities (Respite)		6	6	9	28	6
Community Integration Connection and Skills		19	5	14	26	46

Community Transportation		19	6	9	28	28
Community-Based Residential Services		**0**	4	**0**	3	2
Employment Supports - Co-Worker Supports		8	18	**0**	3	24
Supported Employment - Individual: Career Advancement		12	12	5	15	30
Supported Employment - Individual: Discovery		15	12	5	14	30
Supported Employment - Individual: Exploration		21	22	5	15	30
Supported Employment - Individual: Job Coaching		17	13	5	18	30
Supported Employment - Individual: Job Development Plan		20	16	5	14	30
Supported Employment - Individual: Job Development		20	19	5	16	30
Integrated Employment Path		17	19	**0**	13	30
Supported Employment Small Group		14	6	**0**	**0**	29
Family Empowerment and System Navigation Counseling		13	25	4	8	83
Financial Literacy and Work Incentives Benefits Counseling		16	15	5	5	60
Housing Counseling Services		12	6	1	**0**	65
Housing Start-Up Assistance		12	6	1	**0**	65
Independent Living Skills Training		18	6	10	19	30
Natural Support of Caregiver Education and Training		20	20	20	20	20
Occupational Therapy		**0**	**0**	**0**	**0**	4
Peer Specialist Supports		24	4	7	8	26

Personal Assistance Community		21	13	20	32	31
Personal Assistance Home		14	13	20	32	31
Physical Therapy		**0**	**0**	**0**	**0**	**0**
Positive Behavior Supports		**0**	**0**	**0**	3	28
Remote Supports Backup Contractor		**0**	**0**	**0**	**0**	**0**
Remote Supports Contractor		30	20	20	30	10
Skilled Nursing		**0**	**0**	**0**	**0**	20
Speech and Language Therapy		**0**	**0**	**0**	**0**	4
Supported Living Services		4	**0**	**0**	**0**	20

The State's strategy to address the services noted above where, in specific regions, there is no (0) anticipated capacity to accept new referrals as of the last month of the demonstration year, is described in the Results of the Data Analysis section below that follows the description of the methods.

Method Step #3

Method Step #3: By service and by region, the State will track the number of referrals, the number of referrals accepted, and calculate the referral acceptance rates.

During the entire first year of the CWP demonstration, the COVID-19 public health emergency continued nationwide. According to the terms and conditions of the CWP, the State is required to seek additional providers when, by service and region, the average referral acceptance rate drops below 80%. The data for year one is reported in the table below.

In interpreting the data, it is important to note that the numbers for the year are small due to low annual enrollments, the reasons for which are explained elsewhere in this report. This means a single referral not accepted can have a significant impact on the referral acceptance rate. Additionally, ADMH/DD identified some issues with data entry by Support Coordinators with regard to accurate and complete tracking of referrals made and referrals accepted. To address this, ADMH/DD re-trained Support Coordinators in Q4 and has identified a need to continue this, including regular monthly data integrity reviews, in demonstration year two in order to ensure any remaining data integrity issues are resolved.

Table Abbreviations:

R: Region

#RA: Number of Referrals Accepted

#RNA: Number of Referrals Not Accepted

***RA%: Referral Acceptance Percentage** [Number of Referrals Accepted/Number of Referrals Not Accepted]*

Notes: CWP services not included in above table had no referrals in any region as of 9/30/22.

Service Title: Services Used or Sought	R 1 #RA	R 1 #RNA	R 1 RA%	R 2 #RA	R 2 #RNA	R 2 RA%	R 3 #RA	R 3 #RNA	R 3 RA%	R 4 #RA	R 4 #RNA	R 4 RA%	R 5 #RA	R 5 #RNA	R 5 RA%
Assistive Technology and Adaptive Aids	3	2	60%	0	0	N/A	3	0	100%	10	1	91%	2	0	100%
Breaks and Opportunities	3	1	75%	0	0	N/A	10	2	83%	6	1	86%	1	0	100%
Community Integration Connections and Skills Training	9	3	75%	0	0	N/A	9	1	90%	11	1	92%	5	0	100%
Community transportation	5	5	50%	1	3	25%	9	0	100%	9	1	90%	6	0	100%
Community-Based Residential Services	1	0	100%	1	0	100%	1	0	100%	1	0	100%	1	0	100%
Family Empowerment and Systems Navigation Counseling	0	0	N/A	0	3	0%	0	0	N/A	0	0	N/A	0	0	N/A
Housing Counseling	0	0	N/A	0	1	0%	0	0	N/A	0	0	N/A	0	0	N/A
Housing Start-Up Assistance	0	0	N/A	0	0	N/A	1	0	100%	0	0	N/A	1	0	100%
Independent Living Skills Training	0	0	N/A	0	0	N/A	9	2	82%	9	0	100%	3	0	100%
Occupational Therapy	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	2	0	100%
Peer Specialist	0	0	N/A	1	0	100%	0	0	N/A	1	0	100%	0	0	N/A
Personal Assistance	3	2	60%	3	5	38%	13	2	87%	14	1	93%	2	0	100%
Positive Behavioral Supports	0	0	N/A	0	0	N/A	3	0	100%	0	0	N/A	1	0	100%
Remote Support - Monitoring	0	0	N/A	0	0	N/A	2	1	67%	2	1	67%	2	0	100%
Skilled Nursing - LPN	0	0	N/A	0	0	N/A	0	0	N/A	0	1	0%	0	0	N/A
Speech and Language Therapy	0	0	N/A	0	0	N/A	0	0	N/A	1	0	100%	2	0	100%
Support Coordination	15	1	94%	4	0	100%	23	0	100%	6	0	100%	8	0	100%
Supported Employment	0	0	N/A	1	0	100%	0	0	N/A	3	0	100%	5	0	100%
Work Incentive Benefits Counseling	0	0	N/A	0	1	0%	0	0	N/A	0	0	N/A	1	0	100%

Referral acceptance rates are influenced by CWP participant's choice of provider. Some providers may be available to accept referrals but not selected by a CWP participant. Referral acceptance is counted when ***both*** a provider accepts a referral ***and*** the CWP participant accepts/selects this provider.

The State's strategy to address the services noted above where, in specific regions, there was less than 80% referral acceptance rates during the first demonstration year is described in the Results of the Data Analysis section below that follows the description of the methods.

Method Step #4:

By service and by region, the State will track service initiation delays.

During the entire first year of the CWP demonstration, the COVID-19 public health emergency continued nationwide. According to the terms and conditions of the CWP, the State is required to seek additional providers when, by service and region, the average service initiation delay exceeds sixty (60) days.

Based on average service initiation delays for each quarter of the demonstration year, the average service initiation delay for the first year of the demonstration was forty-nine (49) days with the range from one (1) to one-hundred fifty-eight (158) days.

Method Step #5:

By service and by region, the State will calculate the anticipated need for additional provider capacity to serve planned, new enrollments, basing need on service utilization patterns for existing enrollees.

The number of projected new enrollments (by region) that are expected to occur during the upcoming month (October 2022) are calculated by the CWP Director.

Total New Enrollees Anticipated in First Month of Year two of the Demonstration (October 2022):

Region 1:	13
Region 2:	9
Region 3:	12
Region 4:	9
Region 5:	20
Total Statewide:	**63***

**Pace necessary to achieve 760 additional non-reserve capacity enrollments by end of FY23. This target number includes new slots created by legacy waiver attrition and included in technical amendments submitted to CMS in November 2022.*

For each region, service utilization rates for existing enrollees are used to determine how many projected new enrollees will require each CWP service. For each utilized service in each region, the anticipated number of new enrollees needing each service is included in the table below. Please note that given some existing CWP enrollees are awaiting providers to accept their referrals for certain services (see Method Step #3), these needs are also incorporated into the table on the next page.

The last column shows the conclusion reached regarding whether additional provider capacity is needed.

The State's strategy to address the services noted in the table where, in specific regions, there is an identified need for more capacity is described in the Results of the Data Analysis section below that follows the description of the methods.

Service	Region	# Utilizing	# Waiting	# Enrolled	Utilization Rate	Anticipated New Enrollments	Additional Capacity Needed	Existing Provider-Reported Capacity	More Providers Needed?
Adult Family Home	1	0	1	43	2%	13	1	0	Yes
Adult Family Home	2	0	1	44	2%	9	1	0	Yes
Adult Family Home	3	0	1	37	3%	12	1	0	Yes
Adult Family Home	4	0	1	27	4%	9	1	0	Yes
Adult Family Home	5	0	1	22	5%	20	1	0	Yes
Assistive Technology and Adaptive Aids	1	2	2	43	9%	13	3	339	No
Assistive Technology and Adaptive Aids	2	1	0	44	2%	9	0	227	No
Assistive Technology and Adaptive Aids	3	2	0	37	5%	12	1	236	No
Assistive Technology and Adaptive Aids	4	4	1	27	19%	9	3	339	No
Breaks and Opportunities	1	4	1	43	12%	13	3	0	Yes
Breaks and Opportunities	2	0	0	44	0%	9	0	28	No
Breaks and Opportunities	3	5	2	37	19%	12	4	0	Yes
Breaks and Opportunities	4	6	1	27	26%	9	3	28	No
Breaks and Opportunities	5	0	0	22	0%	20	0	28	No
Community-Based Residential	1	0	0	43	0%	13	0	0	No
Community-Based Residential	2	2	0	44	5%	9	0	2	No
Community-Based Residential	3	1	0	37	3%	12	0	0	No
Community-Based Residential	4	1	0	27	4%	9	0	3	No
Community-Based Residential	5	0	0	22	0%	20	0	2	No
Comm Int Conn and Skills Training	1	8	3	43	26%	13	6	20	No
Comm Int Conn and Skills Training	2	0	0	44	0%	9	0	2	No
Comm Int Conn and Skills Training	3	5	1	37	16%	12	3	24	No
Comm Int Conn and Skills Training	4	0	1	27	4%	9	1	29	No
Comm Int Conn and Skills Training	5	2	0	22	9%	20	2	92	No
Community Transportation	1	8	5	43	30%	13	9	23	No
Community Transportation	2	1	3	44	9%	9	4	34	No
Community Transportation	3	10	0	37	27%	12	3	23	No
Community Transportation	4	7	1	27	30%	9	4	33	No
Community Transportation	5	5	0	22	23%	20	5	75	No
Housing Start Up	3	1	0	37	3%	12	0	4	No
Independent Living Skills Training	1	2	0	43	5%	13	1	39	No
Independent Living Skills Training	2	0	0	44	0%	9	0	2	No
Independent Living Skills Training	3	12	2	37	38%	12	7	10	No
Independent Living Skills Training	4	7	0	27	26%	9	2	22	No
Independent Living Skills Training	5	2	0	22	9%	20	2	76	No
Occupational Therapy	5	2	0	22	9%	20	2	77	No
Peer Specialist Services	4	1	0	27	4%	9	0	8	No
Personal Assistance-Community	1	1	1	43	5%	13	2	39	No
Personal Assistance-Community	2	2	3	44	11%	9	4	13	No
Personal Assistance-Community	3	2	1	37	8%	12	2	25	No
Personal Assistance-Community	4	3	0	27	11%	9	1	35	No
Personal Assistance-Community	5	1	0	22	5%	20	1	77	No
Personal Assistance-Home	1	1	1	43	5%	13	2	39	No
Personal Assistance-Home	2	0	2	44	5%	9	2	13	No
Personal Assistance-Home	3	3	1	37	11%	12	2	25	No
Personal Assistance-Home	4	4	1	27	19%	9	3	35	No
Personal Assistance-Home	5	1	0	22	5%	20	1	77	No
Positive Behavior Supports	1	0	0	43	0%	13	0	39	No
Positive Behavior Supports	2	0	0	44	0%	9	0	13	No
Positive Behavior Supports	3	8	0	37	22%	12	3	25	No
Positive Behavior Supports	4	10	0	27	37%	9	3	35	No
Positive Behavior Supports	5	1	0	22	5%	20	1	30	No
Remote Supports	1	0	0	43	0%	13	0	39	No
Remote Supports	2	0	0	44	0%	9	0	13	No
Remote Supports	3	1	1	37	5%	12	2	220	No
Remote Supports	4	1	1	27	7%	9	2	35	No
Remote Supports	5	0	0	22	0%	20	0	77	No
SE-Discovery	2	1	0	44	2%	9	0	13	No
SE-Discovery	4	0	0	27	0%	9	0	19	No
SE-Discovery	5	3	0	22	14%	20	3	30	No
SE-Exploration	1	0	0	43	0%	13	0	21	No
SE-Exploration	2	1	0	44	2%	9	0	23	No
SE-Exploration	4	3	0	27	11%	9	1	20	No
Speech-Language Therapy	5	2	0	22	9%	20	2	77	No
Work Incentive Benefits Counseling	1	0	0	43	0%	13	0	39	No
Work Incentive Benefits Counseling	2	0	1	44	2%	9	1	13	No
Work Incentive Benefits Counseling	3	0	0	37	0%	12	0	220	No
Work Incentive Benefits Counseling	4	0	0	27	0%	9	0	35	No
Work Incentive Benefits Counseling	5	1	0	22	5%	20	1	25	No

Method Step #6:

By service and by region, during the COVID-19 public health emergency, when providers report they are unable to sufficiently expand the number of beneficiaries they are serving (Method #2) to address planned CWP enrollments (Method #5) and/or they are unable to achieve 80% referral acceptances (Method #3) or achieve timely service initiations (Method #4) for existing CWP enrollees, the State is required to initiate the process to increase the number of providers for the impacted service and region (i.e., selection from the Stand-by List and/or initiation of an RFP).

Results of Data Analysis:

The State's initial effort during year one to collect the data necessary to meet this requirement was hampered by issues with the data collection tools that the State worked to resolve during Q3. While the State was able to collect and report data for some quarters of the first demonstration year (Q1-Q4 for Method #1; Q3 & Q4 for Method #2 and Method #5; Q4 for Method #3 and Method #4), results are not optimized at this time; but are expected to be optimized during demonstration year two so that the State can fully assess the need for additional provider capacity. Additional strategies for obtaining that additional provider capacity, not previously discussed in this report, are discussed below.

The State released an RFP in June 2022 to recruit stand-by providers and, based on the data available to that point, to address specific services by region where inadequate provider capacity appeared to exist based on available data. These specific services and some additional services based on annual/Q4 analysis are:

SERVICE:	NEED	RFP RESULTS
Adult Family Home	All Regions	1 New Provider Added
Assistive Technology and Adaptive Aids	All Regions	2 New Providers Added
Breaks and Opportunities (Unplanned/Emergency)	All Regions	
Community Transportation (Paid Driver; Stand-Alone)	All Regions	
Occupational Therapy	Regions 1-4	
Personal Assistance-Home	Regions 2-3	1 New Provider Added Region 3
Personal Assistance-Community	Regions 2-3	1 New Provider Added Region 3
Positive Behavior Supports	All Regions	
Physical Therapy	Regions 1-4	
Speech Therapy	Regions 1-4	
Supported Employment	Region 4	
Peer Specialist	Region 3	
Supported Living Services	Regions 2-5	

The above new providers will be contracted during demonstration year two, quarter 1.

For Breaks and Opportunities (Unplanned/Emergency), Project Transition (discussed previously in this report) is being contracted in demonstration year two to begin offering this service in two regions. Additionally, they are being contracted to mentor existing ADMH/DD waiver providers who have vacant group homes in CWP counties which they want to repurpose to become Breaks and Opportunities (Unplanned/Emergency) settings with technical assistance, training, and support from Project Transition. The goal is to achieve full statewide capacity by the end of demonstration year two.

For Positive Behavior Supports, Project Transition is also being contracted in demonstration year two to begin offering their own model for this service in two regions. Additionally, they are being contracted to mentor existing CWP providers who are contracted for this service or who have qualified personnel to deliver this service on their existing staff. Benchmark is already under contract with ADMH/DD to provide this mentoring as well, but will expand its involvement with the CWP in this way in demonstration year two. Finally, ADMH/DD is working on bringing the START model (University of New Hampshire) to the Alabama CWP program to focus this model on providing supports for families and natural supports to successfully learn and utilize Positive Behavior Support strategies with CWP participants who are living with them, in order to proactively prevent crisis and temporary or permanent out of home placement.

For therapies, existing contracted CWP providers in Region 5 with staff qualified to deliver all three therapies will be able to apply to extend access to these services to the other four regions by subcontracting with qualified therapists located in other regions. This modified subcontracting arrangement, allowing the arrangement only if the billing provider is a therapies provider itself, will be supported by the proposed year two waiver amendment.

Personal Assistance Home and Community (Region 2), Supported Employment (Region 4), Peer Specialist (Region 3) and Supported Living (Regions 2 to 5) are also targeted for specific provider recruitment efforts through the RFP. The State

believes that the changes adopted because of the rate study, permanent rate increases to sustain the 30% rate enhancements currently being paid using state funds, and corresponding expenditure cap increases must be in place before additional RFP efforts will result in successful recruitment of additional providers.

The issues with the lack of capacity for Remote Supports-Monitoring (Regions 3, 4) and Remote Supports-Back-Up Contractor (All Regions) appears to be due to the lack of CWP participant education regarding options for Monitoring, given that contracted providers report significant capacity to accept new referrals. In demonstration year two, Support Coordinators will be trained to ensure CWP participants needing this service have the opportunity to meet each of the providers. For Remote Supports-Back Up Contractor, ADMH/DD believes the lack of provider capacity to accept new referrals relates to provider misunderstanding of the reimbursement methodology. ADMH/DD will do additional training with providers contracted for this service to ensure the methodology and appropriateness of the rate is understood by these providers.

Rates for Community Transportation (Paid Driver; Stand-Alone Service) will be evaluated through the year one rate study results and additional ADMH/DD evaluation to determine if a change in the rates or rate methodology is needed to attract sufficient providers for the CWP. Any rate or rate methodology changes will be included in the CWP waiver amendment planned for demonstration year two.

After the planned CWP waiver amendment to increase reimbursement rates and expenditure caps, as described above, is posted for public comment, submitted to CMS and approved by CMS, ADMH/DD plans to issue a new RFP for standby providers and to fill any remaining provider network needs, as identified through quarterly ongoing monitoring of provider network capacity using the methods detailed above.

Conclusion:

The first year of the Community Waiver Program, while highly challenged with regard to enrollment difficulties and the unprecedented direct service workforce crisis resulting from the COVID-19 pandemic and its aftermath, has shown promising outcomes for enrollees. On key performance metrics, the Community Waiver Program's early results are cause for confidence in the program's ability to achieve its intended goals:

- **173** net enrollments achieved with individuals on the waiting list who desire enrollment already identified for nearly all of remaining the non-reserve capacity enrollment slots.
- Individuals who have been waiting the longest for services are getting the opportunity to finally receive HCBS services, with **47%** of those enrolled in the first demonstration year having waited 10 years or more.
- **53.6%** of individuals enrolled are interested in achieving community employment with 9.4% already working in community jobs and earning a competitive wage. This is nearly five times the rate of competitive integrated employment in the legacy waivers prior to the COVID-19 pandemic.
- **28.6%** participation rate in self-direction.

Most importantly, the Community Waiver Program is showing early signs of achieving its goals of keeping families together and preventing crises that may lead to family breakup and costly, restrictive out-of-home placements, which in turn reduces how many Alabamians with ID in need can get services. By prioritizing these goals:

- **92%** of participants are being supported to sustain their family living arrangement, live with other natural supports or live in an independent living arrangement.
- **92%** of participants are receiving **all** CWP services in settings that are not provider owned or controlled.
- **70%** of emergency referrals assumed to need group home placement have been successfully served using less restrictive and less costly solutions.

Through the federally approved use of legacy waiver attrition slot funding, the Community Waiver Program is expected to be able to eliminate the waiting list in the eleven counties where it currently operates by no later than the end of demonstration year three. The planned strategies for implementation in demonstration year two also provide a path to stabilizing its provider network to ensure timely access to chosen providers and services for CWP participants, as enrollment in the program grows as a result of eliminating the waiting list.

With regard to the CWP provider network, its struggles are highly aligned with the struggles of I/DD HCBS providers nationally. It is important to note that the core problem with provider network adequacy continues to be a need for more DSPs to deliver services. However, there is little evidence to suggest that simply adding more provider agencies to the CWP network will create this additional direct service staffing capacity. In the absence of other changes, this only results in a greater number of provider agencies competing for the same limited pool of job seekers willing and able to take the positions. Therefore, the State has devised a set of solutions, as described in this report, which the State plans to implement in demonstration year two. These solutions are expected to have a much greater and more effective impact on the shortage of DSPs and the related referral acceptance rates and service initiation delays.

There are bright spots reflected in the Community Waiver Program provider network, despite the unprecedented crisis and challenges it is facing. While the minimum PPQ score for a provider to be admitted to the CWP network is twelve (12), ADMH/DD has been able to recruit and establish a provider network for the CWP during the first demonstration year that collectively achieved an average PPQ Score of twenty-four (24). The unique re-credentialing process developed includes a focus on each provider taking steps to increase its PPQ score. ADMH/DD's unique "Provider Readiness Initiative" continues to utilize dedicated resources to support provider network success, competency-based DSP training and specialized trainings for a range of CWP services. Additionally, new providers are coming to Alabama to be involved in the CWP, bringing their expertise and experience gained from working in many other states. Alabama providers and new providers are working together, sharing expertise and resources to serve CWP participants in the best ways possible.

While the first demonstration year involved many challenges, the State is confident that the program will continue to demonstrate positive outcomes and overcome many of the challenges in the coming years.

Quarter Four Information:

Data Demonstrating How the State is Progressing Toward Meeting the Demonstration's Goals

Program Goal #A1: Enroll five hundred (500) participants in first year of CWP.

Metric #1: Total enrollments as compared to total targeted enrollments for the reporting period

Numerator: Total enrollments for the reporting period.
Denominator: Total targeted enrollments for the reporting period.

Data Collection Methodologies: Enrollments are entered into Alabama Department of Intellectual Disabilities Information System for Case Management and Claims Billing (ADIDIS), on the Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing enrollments during the reporting period is pulled from ADIDIS to obtain the numerator. The denominator is based on the table below illustrating the Anticipated Pace of Enrollments, which corresponds with each quarterly and the first annual STC reporting periods.

Anticipated Pace of Enrollments (Updated April 2022)	Total Targeted Enrollments Statewide (Not including reserve capacity)	% of Total Enrollments in Year 1 of CWP (Not including reserve capacity)
November-December 2021	35	8%
January-March 2022	24	5%
April-June 2022	184	42%
July-September 2022	200	45%
Total Slots (not including reserve capacity)	443	100%

Data for the Reporting Period:

Total Enrollments for the Reporting period	Total Targeted Enrollments	Performance
42	**200**	**20%**

The enrollments for the Q4 by region, county and enrollment group are as follows:

Demonstration Month	County	Enrollment Group				
July 2022		**Gr 1**	**Gr 2**	**Gr 3**	**Gr 4**	**Gr 5**
Region 1	Madison		1			
	Morgan			1		
	Limestone					
Region 2	Tuscaloosa			2		
	Walker					
Region 3	Mobile			1		
	Baldwin					
Region 4	Montgomery					

	Elmore					
	Houston					
Region 5	Jefferson		1	4		
July 2022 TOTAL:			2	8		
August 2022		**Gr 1**	**Gr 2**	**Gr 3**	**Gr 4**	**Gr 5**
Region 1	Madison			1		
	Morgan					
	Limestone					
Region 2	Tuscaloosa		5	7		
	Walker			1		
Region 3	Mobile		4			
	Baldwin		1	1		
Region 4	Montgomery					
	Elmore					
	Houston			1		
Region 5	Jefferson			1		
August 2022 TOTAL:			10	12		
September 2022		**Gr 1**	**Gr 2**	**Gr 3**	**Gr 4**	**Gr 5**
Region 1	Madison		1			
	Morgan		1			
	Limestone					
Region 2	Tuscaloosa					
	Walker			2		
Region 3	Mobile					
	Baldwin					
Region 4	Montgomery					
	Elmore			1		
	Houston					
Region 5	Jefferson			5		
September 2022 TOTAL:			2	8		
REPORTING PERIOD TOTAL	**ALL COUNTIES**	**Gr 1**	**Gr 2**	**Gr 3**	**Gr 4**	**Gr 5**

ALL REGIONS	**42**	**0**	**14**	**28**		

Program Goal #A2: Support participation in competitive integrated employment by CWP participants

Metric #1: *Percentage of working-age CWP participants who enrolled with a goal to obtain or maintain competitive integrated employment*

Numerator: Total CWP enrollments, ages 14-64, with enrollment priority for obtaining or maintaining competitive integrated employment.

Denominator: Total CWP enrollments, ages 14-64, for the reporting period.

Data Collection Methodologies: When enrollments are entered by the Regional Office Wait List Coordinator, the ADIDIS "Demographics" screen is also filled in using data from CWP Waitlist Details Database, including the enrollment priority category. ADMH/DD is using this demographics screen data in ADIDIS for this metric, which tracks each CWP enrollee's Enrollment Priority Category selected from the following options:

4. Preserve existing living arrangement.
5. Obtain/maintain competitive integrated employment.
6. Preserve existing living arrangement AND obtain/maintain competitive integrated employment.

New enrollees during the reporting period, ages 14-64 and in categories two (2) and three (3), are counted in the numerator.

Enrollments are entered into the ADIDIS system's Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing all new enrollments, for individuals ages 14-64, during the reporting period is pulled from ADIDIS to obtain the denominator.

Data for the Reporting Period:

Total CWP enrollments, ages 14-64, with enrollment priority for obtaining or maintaining competitive integrated employment	Total CWP enrollments, ages 14-64, for the reporting period	Performance
18	**41**	**44%**

Program Goal #A3: Keep families together and supporting independent living as the optimal community living options

Metric #1*: % of CWP participants that are living with family/natural supports or living in an independent living arrangement.*

Numerator: Total CWP participants as of the last day of the reporting period that are living with family or other natural supports or living in an independent living arrangement.

Denominator: Total CWP participants as of the last day of the reporting period.

Data Collection Methodologies:
Within the first thirty (30) days of enrollment, Support Coordinators are responsible for obtaining and entering correct information on "Residence Type" into ADIDIS "Demographics" screen for each CWP participant. A "Date Residence Type Updated" field is also required to confirm updating of the Residence Type field is occurring at regular intervals. On a quarterly basis, after initial enrollment, the Support Coordinator is required to collect and record updated information on Residence Type using the required "CWP Face-to-Face Visit Tool." The Support Coordinator is then required to use information collected to update the "Residence Type" and "Date Residence Type Updated" in the ADIDIS "Demographics" screen for each CWP participant. A report is pulled from ADIDIS as of the last day of the reporting period to determine how many CWP participants, as of the last day of the reporting period, have a residence type that indicates they are living with family/natural supports or living in an independent living arrangement. This number is the numerator. Data from the ADIDIS CWP Participant File is pulled, as of the last day of the reporting period, to obtain the denominator.

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period that are living with family or other natural supports or living in an independent living arrangement	Total CWP participants as of the last day of the reporting period	Performance
159	**173**	**92%**

Program Goal #A4: Support use of self-direction by CWP participants

Metric #1*: % of CWP participants who are opting to self-direct one (1) or more of their services.*

Numerator: Total CWP participants as of the last day of the reporting period who have one (1) or more services in their Person-Centered Plans that can be self-directed and who are self-directing at least one (1) of those services.

Denominator: Total CWP participants as of the last day of the reporting period who have one (1) or more services in their Person-Centered Plans that can be self-directed.

Data Collection Methodologies: Regional Office Fiscal Managers enter service authorizations into ADIDIS from approved Person-Centered Plans for CWP participants, previously entered into ADIDIS by Support Coordinators. The denominator is generated by running a report from the ADIDIS CWP Participant File, as of the last day of the reporting period, to obtain the complete list of CWP participants. For this list of CWP participants, a service authorizations report is then run, as of the last day of the reporting period, for all CWP service types that can be self-directed. The total number of CWP participants with one (1) or more CWP service types that can be self-directed authorized, constitute the denominator.

For those CWP participants included in the denominator, a service authorizations report is run, as of the last day of the reporting period, for all CWP service codes that indicate self-directed services are authorized. All CWP participants included in the denominator that have at least one (1) self-directed service code authorized, as of the last day of the reporting period, are counted in the numerator.

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period who have one or more services in their Person-Centered Plans that can be self-directed and who are self-directing at least one of those services	Total CWP participants as of the last day of the reporting period who have one or more services in their Person-Centered Plans that can be self-directed	Performance
26	91	28.6%

Data demonstrating the effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured population

Program Goal #B1: Increase access to Medicaid for uninsured individuals with intellectual disabilities

Metric #1*: % of CWP participants enrolled during the reporting period who qualified for and/or first received Medicaid coverage as a result of CWP enrollment.*

Numerator: Total CWP enrollees during the reporting period who initially qualified for and/or first received Medicaid coverage as a result of CWP enrollment.

Denominator: Total CWP enrollments during the reporting period.

Data Collection Methodologies: Enrollments are entered into the ADIDIS Regional Office Waiver Registration Screen by the Regional Office Waiver Coordinator. A report summarizing enrollments during the reporting period is pulled from ADIDIS to obtain the denominator.

Data for the Reporting Period:

Total CWP enrollees during the reporting period who qualified for and/or first received Medicaid coverage as a result of CWP enrollment	Total CWP enrollments during the reporting period	Performance
0	42	0%

Data demonstrating quality of care

Program Goal #C1: Ensure high CWP participant satisfaction

Metric #1: *% of CWP participants surveyed during quality monitoring activities conducted during the reporting period who have measured satisfaction with the CWP that is at least 85%.*

Numerator: Total number of CWP participants surveyed during quality monitoring activities conducted during the reporting period whose measured satisfaction with the CWP is at least 85%.

Denominator: Total number of CWP participants surveyed during quality monitoring activities conducted during the reporting period.

Data Collection Methodologies: Data is pulled from "CWP Participant Satisfaction Survey" database in which CWP Quality Monitoring staff enter the date and results of each CWP Participant Satisfaction Survey conducted during the reporting period as part of provider re-credentialing processes. A report is pulled after the end of each reporting period that contains information on the total number of CWP Participant Satisfaction Surveys completed during the reporting period. This number is the denominator.

When the Quality Monitoring staff enter the results for each CWP Participant Satisfaction Survey conducted during the reporting period, the entries result in a calculated satisfaction percentage. Among all CWP Participant Satisfaction Surveys completed during the reporting period, every survey with a calculated satisfaction percentage of 85% or higher is counted in the numerator.

Data for the Reporting Period:

Total CWP participants surveyed during quality monitoring activities conducted during the reporting period whose measured satisfaction with the CWP is at least 85%	Total CWP participants surveyed during quality monitoring activities conducted during the reporting period	Performance
N/A	**N/A**	**N/A**

N/A Explanation:
The CWP Participant Satisfaction Survey is being implemented as part of provider re-credentialing visits in year two of the demonstration. This re-credentialing process commences within six (6) months after a provider begins to deliver services to at least one individual referred through the CWP and includes a series of visits throughout the year focused on different topical areas for recredentialing. Due to this reporting period being Q4 of the first year of the program, this re-credentialing process had begun in year one; but no providers had received the specific visit that included use of the Participant Satisfaction Survey tool. ADMH/DD anticipates being able to report data on this metric in the year two monitoring reports.

Metric #2: % of CWP participants filing a grievance and/or appeal during the reporting period.

Numerator: Total CWP participants filing a grievance and/or appeal during the reporting period.

Denominator: Total CWP participants as of the last day of the reporting period.

Data Collection Methodologies: Data on all filed grievances and appeals is documented in the ADMH/DD Office of Appeals and Constituency Affairs' grievance and appeals database, which will be used to pull the number of newly filed grievances and appeals during the reporting period.

Data from the ADIDIS CWP Participant File is pulled, as of the last day of the reporting period, to obtain the denominator.

Data for the Reporting Period:

Total CWP participants filing a grievance and/or appeal during the reporting period	Total CWP participants as of the last day of the reporting period	Performance
0	**173**	**0%**

Data Demonstrating Results of Key Policies Adopted Under the Demonstration

Key Policy #D1: Utilize settings that conform to the greatest extent with the Medicaid Home and Community Based Services (HCBS) Settings Final Rule

Metric #1: *% of CWP participants receiving all services in settings that are not provider owned or controlled.*

Numerator: Total CWP participants as of the last day of the reporting period with approved Person-Centered Plans who are receiving all CWP services* in settings that are not provider owned or controlled**.

**All CWP services is defined as all CWP services on the Person-Centered Plan except:*

- *Occupational Therapy*
- *Physical Therapy*
- *Speech/Language Therapy*
- *Community Transportation*
- *Individual-Directed Goods and Services*

***Provider owned, or controlled settings are defined as specific, physical places, in which a CWP participant resides and/or receives CWP services, that are owned, co-owned, and/or operated by a provider of CWP services.*

Denominator: Total CWP participants as of the last day of the reporting period with approved Person-Centered Plans.

Data Collection Methodologies: Regional Office Fiscal Managers enter service authorizations into ADIDIS from approved Person-Centered Plans for CWP participants that have been entered into ADIDIS by Support Coordinators.

The denominator is generated by running a report from the ADIDIS CWP Participant File, as of the last day of the reporting period, to obtain the complete list of CWP participants. Then, using this list of CWP participants, a service authorizations report is run, as of the last day of the reporting period, to identify the sub-set that has services authorized indicating an approved Person-Centered Plan is in place. This generates the denominator.

For the numerator, a service authorization report will be run for each CWP participant included in the denominator. Authorizations for the following service types will be excluded:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Community Transportation
- Individual-Directed Goods and Services

Remaining authorizations for each CWP participant will be analyzed. A CWP participant will be counted in the numerator if none of the following authorizations appear in their remaining authorizations:

- Community-Based Residential Services
- Adult Family Home

Data for the Reporting Period:

Total CWP participants as of the last day of the reporting period with approved Person-Centered Plans who are receiving all CWP services* in settings that are not provider owned or controlled**	Total CWP participants as of the last day of the reporting period with approved Person-Centered Plans	Performance
104	**113**	**92%**

Monitoring Provider Capacity

Q4 Method Step #1:

By service and by region, the State will report any changes to the number of preferred providers.

At the end of Q4, there were thirty-three (33) providers collectively providing thirty-three (33) CWP services across the five (5) regions. This represents no change from Q3.

Q4 Method Step #2:

By region, the State will assess existing providers prospective capacity to accept additional referrals for each service.

Existing CWP providers' Q4 reports on prospective capacity are summarized in the chart below:

CWP Service Type	Providers' Reported Capacity to Accept New Referrals in Quarter 1 Month #1 of Demonstration Year two (Oct 2022)				
	REGION 1 TOTAL	REGION 2 TOTAL	REGION 3 TOTAL	REGION 4 TOTAL	REGION 5 TOTAL
Adult Family Home	3	**0**	2	1	**0**
Assistive Technology and Adaptive Aids	54	40	44	55	25
Breaks and Opportunities (Respite)	**0**	2	5	22	4
Community Integration Connection and Skills	19	6	14	26	46
Community Transportation	19	12	9	28	28
Community-Based Residential Services	**0**	4	**0**	3	2
Employment Supports - Co-Worker Supports	8	18	**0**	2	24
Supported Employment - Individual: Career Advancement	12	12	5	4	30
Supported Employment - Individual: Discovery	15	12	5	3	30
Supported Employment - Individual: Exploration	21	22	5	4	30
Supported Employment - Individual: Job Coaching	17	13	5	17	30
Supported Employment - Individual: Job Development Plan	20	16	5	13	30
Supported Employment - Individual: Job Development	20	19	5	15	30

Supported Employment - Integrated Employment Path	17	19	0	2	30
Supported Employment Small Group	14	6	0	0	29
Family Empowerment and System Navigation Counseling	13	35	4	8	83
Financial Literacy and Work Incentives Benefits Counseling	16	15	5	5	60
Housing Counseling Services	30	15	0	0	65
Housing Start-Up Assistance	9	15	0	0	65
Independent Living Skills Training	40	16	10	19	30
Natural Support of Caregiver Education and Training	20	20	20	20	20
Occupational Therapy	0	0	0	0	4
Peer Specialist Supports	45	4	7	8	26
Personal Assistance Community	16	10	16	26	29
Personal Assistance Home	9	10	16	26	29
Physical Therapy	0	0	0	0	5
Positive Behavioral Supports	0	0	0	3	28
Remote Supports Backup Contractor	0	0	0	0	0
Remote Supports Contractor	30	20	20	30	10
Skilled Nursing	0	0	0	0	20
Speech and Language Therapy	0	0	0	0	4
Supported Living Services	4	0	0	0	20

Method Step #3

Method Step #3: By service and by region, the State will track the number of referrals, the number of referrals accepted, and calculate the referral acceptance rates.

During Q3, the COVID-19 public health emergency continued nationwide. According to the terms and conditions of the CWP, the State is required to seek additional providers when, by service and region, the average referral acceptance rate drops below 80%. The data for Q3 is reported in the table below.

In interpreting the data, it is important to note that the numbers are very small at this early stage, and this means a single referral not accepted can have a significant impact on the referral acceptance rate. Additionally, ADMH/DD identified some issues with data entry by Support Coordinators with regard to accurate and complete tracking of referrals made and referrals accepted. To address this, ADMH/DD will continue to re-train Support Coordinators in demonstration year two and continue tracking data to ensure issues are resolved.

Table Abbreviations:

R: Region

#RA: Number of Referrals Accepted

#RNA/AR: Number of Referrals Not Accepted

RA%: Referral Acceptance Percentage *[Number of Referrals Accepted/Number of Referrals Not Accepted]*

Service Title: Services Used or Sought	R 1 #RA	R 1 #RNA	R 1 RA%	R 2 #RA	R 2 #RNA	R 2 RA%	R 3 #RA	R 3 #RNA	R 3 RA%	R 4 #RA	R 4 #RNA	R 4 RA%	R 5 #RA	R 5 #RNA	R 5 RA%
Assistive Technology and Adaptive Aids	0	0	N/A	0	0	N/A	0	0	N/A	3	1	**75%**	2	0	100%
Breaks and Opportunities	1	0	100%	0	0	N/A	5	1	83%	2	1	**67%**	0	0	N/A
Community Integration Connections and Skills Training	0	0	N/A	0	0	N/A	3	0	100%	6	0	100%	4	0	100%
Community transportation	0	0	N/A	1	1	**50%**	4	0	100%	4	0	100%	4	0	100%
Community-Based Residential Services	1	0	100%	0	0	N/A	1	0	100%	0	0	N/A	0	0	N/A
Family Empowerment and Systems Navigation Counseling	0	0	N/A	0	2	**0%**	0	0	N/A	0	0	N/A	0	0	N/A
Housing Counseling	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A
Housing Start-Up Assistance	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	1	**0%**
Independent Living Skills Training	0	0	N/A	0	0	N/A	3	0	100%	7	0	100%	3	0	100%
Occupational Therapy	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	2	0	100%
Peer Specialist	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A
Personal Assistance	0	0	N/A	3	1	**75%**	4	0	100%	6	1	86%	0	0	N/A
Positive Behavioral Supports	0	0	N/A	0	0	N/A	2	0	100%	0	0	N/A	0	1	**0%**
Remote Support - Monitoring	0	0	N/A	0	0	N/A	0	0	N/A	1	0	100%	2	0	100%
Self-Directed Skilled Nursing - LPN	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A
Speech and Language Therapy	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	2	0	100%
Support Coordination	2	0	100%	1	0	100%	9	0	100%	3	0	100%	3	0	100%
Supported Employment	0	0	N/A	1	0	100%	0	0	N/A	0	0	N/A	3	0	100%

Service Title: Services Used or Sought	R 1 #RA	R 1 #RNA	R 1 RA%	R 2 #RA	R 2 #RNA	R 2 RA%	R 3 #RA	R 3 #RNA	R 3 RA%	R 4 #RA	R 4 #RNA	R 4 RA%	R 5 #RA	R 5 #RNA	R 5 RA%
Work Incentive Benefits Counseling	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A

Notes: CWP services not included in above table had no current authorizations in any region as of 9/30/22. Referral acceptance rates influenced by CWP participant's choice of provider. Some providers may be available to accept referrals but not selected by a CWP participant.

Method Step #4:

By service and by region, the State will track service initiation delays.

During Q3, the COVID-19 public health emergency continued nationwide. According to the terms and conditions of the CWP, the State is required to seek additional providers when, by service and region, the average service initiation delay exceeds sixty (60) days.

Based on all service initiations tracked and reported in Q3, the average length of time from referral acceptance to service start was sixty-four (64) days with the range from fourteen (14) to one hundred-twenty (120) days.

Method Step #5:

By service and by region, the State will calculate the anticipated need for additional provider capacity to serve planned, new enrollments, basing need on service utilization patterns for existing enrollees.

The number of projected new enrollments (by region) that are expected to occur during the upcoming month are calculated by the CWP Director.

Total New Enrollees Anticipated in Next Month:

Region 1:	13
Region 2:	9
Region 3:	12
Region 4:	9
Region 5:	20
Total Statewide:	63*

**Pace necessary to achieve 760 additional non-reserve capacity enrollments by end of FY23. This target number includes new slots created by legacy waiver attrition and included in technical amendments submitted to CMS in November 2022.*

For each region, service utilization rates for existing enrollees are used to determine how many projected new enrollees will require each CWP service. For each utilized service in each region, the anticipated number of new enrollees needing each service is included in the table on the next page. Please note that given the existing CWP enrollees who are awaiting providers to accept their referrals for certain services (see Method Step #3), these needs are also incorporated into the table on the next page.

The last column shows the conclusion reached regarding whether additional provider capacity is needed.

Service	Region	# Utilizing	# Waiting	# Enrolled	Utilization Rate	Anticipated New Enrollments	Additional Capacity Needed	Existing Provider-Reported Capacity	More Providers Needed?
Adult Family Home	1	0	1	43	2%	13	1	0	Yes
Adult Family Home	2	0	1	44	2%	9	1	0	Yes
Adult Family Home	3	0	1	37	3%	12	1	0	Yes
Adult Family Home	4	0	1	27	4%	9	1	0	Yes
Adult Family Home	5	0	1	22	5%	20	1	0	Yes
Assistive Technology and Adaptive Aids	1	2	2	43	9%	13	3	339	No
Assistive Technology and Adaptive Aids	2	1	0	44	2%	9	0	227	No
Assistive Technology and Adaptive Aids	3	2	0	37	5%	12	1	236	No
Assistive Technology and Adaptive Aids	4	4	1	27	19%	9	3	339	No
Breaks and Opportunities	1	4	1	43	12%	13	3	0	Yes
Breaks and Opportunities	2	0	0	44	0%	9	0	28	No
Breaks and Opportunities	3	5	2	37	19%	12	4	0	Yes
Breaks and Opportunities	4	6	1	27	26%	9	3	28	No
Breaks and Opportunities	5	0	0	22	0%	20	0	28	No
Community-Based Residential	1	0	0	43	0%	13	0	0	No
Community-Based Residential	2	2	0	44	5%	9	0	2	No
Community-Based Residential	3	1	0	37	3%	12	0	0	No
Community-Based Residential	4	1	0	27	4%	9	0	3	No
Community-Based Residential	5	0	0	22	0%	20	0	2	No
Comm Int Conn and Skills Training	1	8	3	43	26%	13	6	20	No
Comm Int Conn and Skills Training	2	0	0	44	0%	9	0	2	No
Comm Int Conn and Skills Training	3	5	1	37	16%	12	3	24	No
Comm Int Conn and Skills Training	4	0	1	27	4%	9	1	29	No
Comm Int Conn and Skills Training	5	2	0	22	9%	20	2	92	No
Community Transportation	1	8	5	43	30%	13	9	23	No
Community Transportation	2	1	3	44	9%	9	4	34	No
Community Transportation	3	10	0	37	27%	12	3	23	No
Community Transportation	4	7	1	27	30%	9	4	33	No
Community Transportation	5	5	0	22	23%	20	5	75	No
Housing Start Up	3	1	0	37	3%	12	0	4	No
Independent Living Skills Training	1	2	0	43	5%	13	1	39	No
Independent Living Skills Training	2	0	0	44	0%	9	0	2	No
Independent Living Skills Training	3	12	2	37	38%	12	7	10	No
Independent Living Skills Training	4	7	0	27	26%	9	2	22	No
Independent Living Skills Training	5	2	0	22	9%	20	2	76	No
Occupational Therapy	5	2	0	22	9%	20	2	77	No
Peer Specialist Services	4	1	0	27	4%	9	0	8	No
Personal Assistance-Community	1	1	1	43	5%	13	2	39	No
Personal Assistance-Community	2	2	3	44	11%	9	4	13	No
Personal Assistance-Community	3	2	1	37	8%	12	2	25	No
Personal Assistance-Community	4	3	0	27	11%	9	1	35	No
Personal Assistance-Community	5	1	0	22	5%	20	1	77	No
Personal Assistance-Home	1	1	1	43	5%	13	2	39	No
Personal Assistance-Home	2	0	2	44	5%	9	2	13	No
Personal Assistance-Home	3	3	1	37	11%	12	2	25	No
Personal Assistance-Home	4	4	1	27	19%	9	3	35	No
Personal Assistance-Home	5	1	0	22	5%	20	1	77	No
Positive Behavior Supports	1	0	0	43	0%	13	0	39	No
Positive Behavior Supports	2	0	0	44	0%	9	0	13	No
Positive Behavior Supports	3	8	0	37	22%	12	3	25	No
Positive Behavior Supports	4	10	0	27	37%	9	3	35	No
Positive Behavior Supports	5	1	0	22	5%	20	1	30	No
Remote Supports	1	0	0	43	0%	13	0	39	No
Remote Supports	2	0	0	44	0%	9	0	13	No
Remote Supports	3	1	1	37	5%	12	2	220	No
Remote Supports	4	1	1	27	7%	9	2	35	No
Remote Supports	5	0	0	22	0%	20	0	77	No
SE-Discovery	2	1	0	44	2%	9	0	13	No
SE-Discovery	4	0	0	27	0%	9	0	19	No
SE-Discovery	5	3	0	22	14%	20	3	30	No
SE-Exploration	1	0	0	43	0%	13	0	21	No
SE-Exploration	2	1	0	44	2%	9	0	23	No
SE-Exploration	4	3	0	27	11%	9	1	20	No
Speech-Language Therapy	5	2	0	22	9%	20	2	77	No
Work Incentive Benefits Counseling	1	0	0	43	0%	13	0	39	No
Work Incentive Benefits Counseling	2	0	1	44	2%	9	1	13	No
Work Incentive Benefits Counseling	3	0	0	37	0%	12	0	220	No
Work Incentive Benefits Counseling	4	0	0	27	0%	9	0	35	No
Work Incentive Benefits Counseling	5	1	0	22	5%	20	1	25	No

Method Step #6:

By service and by region, during the COVID-19 public health emergency, when providers report they are unable to sufficiently expand the number of beneficiaries they are serving (Method #2) to address planned CWP enrollments (Method #5) and/or they are unable to achieve 80% referral acceptances (Method #3) or achieve timely service initiations (Method #4) for existing CWP enrollees, the State is required to initiate the process to increase the number of providers for the impacted service and region (i.e., selection from the Stand-by List and/or initiation of an RFP).

Results of Data Analysis:

Multiple measures of provider network capacity as compared to need demonstrate more capacity is needed. The core problem with provider network adequacy continues to be a need for more direct DSPs to deliver services. However, there is little evidence to suggest that simply adding more provider agencies to the CWP network will create this additional direct service staffing capacity. In the absence of other changes, this only results in a greater number of provider agencies competing for the same limited pool of job seekers willing and able to take the positions. Therefore, the State has devised a set of solutions, as described in Method Step #6 of the annual section of this report, which the State plans to implement in demonstration year two. These solutions are expected to have a much greater and more effective impact on the shortage of DSPs and the related referral acceptance rates and service initiation delays. The State intends to release an RFP after this set of solutions is put in place.

Appendix A

Indicators for Preferred Provider Selection

Each PPQ is weighted on a score from two (2) to five (5) based on the relevant strength of the indicator in predicting the provider's ability to deliver CWP services effectively.

- Minimum score to be a Preferred Provider = twelve (12) resulting from a positive score in at least three (3) of the five (5) areas identified below to qualify. This means the provider must earn points for a minimum of one (1) component in three (3) of the five (5) areas and achieve a total score of twelve (12) or higher to qualify.

  Exception for providers serving a beneficiary that voluntarily transitions from the ID or LAH Waiver into the CWP: If the transferring provider does not meet the minimum score of twelve (12), but does score between nine (9) and eleven (11), the transferring provider will have a six-month grace period to achieve a minimum score of twelve (12), resulting from a positive score in at least three (3) of the five (5) factors – but only if the transferring provider contractually agrees to receive technical assistance from the State during the grace period to help the provider achieve the minimum qualifying score. During this grace period, the transferring provider will only be allowed to serve the transferring beneficiary from the ID or LAH Waiver. After the grace period, if the provider successfully achieves the minimum qualifying score to be a preferred provider, as described in Attachment D, the provider will be permitted to compete and be selected in a subsequent RFP process to serve all CWP beneficiaries.
- Maximum possible score is fifty (50).

Area I. Experience with Waiver Service Provision

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

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

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

Area II. Independent Accreditation

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

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

B. The provider has obtained Systemic, Therapeutic, Assessment, Resources, and Treatment (START) program certification, START network partner certification, or has at least one (1) staff person who has completed START coordination certification and whose time will be at least 50% dedicated to serving referrals from the CWP, as verified by the provider's proposed staffing chart for the CWP. (3 Points)

Area III. Support of Person-Centered Service Delivery

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

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

C. The provider is willing and able to recruit and provide staff who are linguistically competent in spoken languages other than English when one (1) of these languages is the primary language of individuals enrolled in the CWP and/or their primary caregivers, verifiable by provider policy and staff position descriptions/contracts. (2 Points)

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

Area IV. Support of Independent Living

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

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

Area V. Support of Integrated, Competitive Employment and Community Inclusion

A. The provider has experience assisting individuals with intellectual disabilities to obtain and/or maintain individualized, competitive, integrated employment where an HCBS service provider is not the employer of record. This is evidenced by the provider's data, for a three-month period with an end date within six (6) months of applying to become a CWP provider, showing the percentage of individuals with intellectual disabilities served (regardless of services provided) who are working in individualized, competitive, integrated employment is at least 15%. (4 Points)

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

C. The provider can demonstrate relationships with other non-disability specific and non-Medicaid funded community organizations, associations and/or businesses that can be leveraged to assist individuals with intellectual disabilities in pursuing and achieving employment and integrated community involvement goals, as evidenced by at least three (3) letters of commitment from such community-based organizations to work with the providers in order to help persons supported by the provider to achieve such goals. Three (3) letters of commitment are required per county that the provider is applying to serve through the CWP. Letters of commitment from other ID, LAH, CWP, Autism, or mental health service providers will not be counted. (4 Points)

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

Appendix B

Alabama Community Waiver Program Demonstration Evaluation

2022 Annual Summary of Progress

Key Activities and Accomplishments

As the independent evaluator, Health Management Associates (HMA) spent the year prior to the launch of the Community Waiver Program (CWP) Demonstration working with the state to identify data sources and develop the evaluation design. The waiver was approved by CMS on October 21, 202,1 and opened to participant enrollment on November 1, 2021. Key activities and accomplishments for the first year of the evaluation (October 21, 2021 through September 30, 2022) are presented in Table 1 below.

Table 1. Year one Key Activities and Accomplishments

Quarter One 10/21/21 - 12/31/21	*Quarter Two 1/1/22 - 3/31/22*	*Quarter Three 4/1/22 - 6/30/22*	*Quarter Four 7/1/22 - 9/30/22*
• Refined proposed evaluation measures for testing the hypotheses and research questions as submitted in the demonstration application • Identified data sources • Developed surveys and other data collection opportunities • Piloted provider survey • Implemented new data input processes for both the demonstration data and the control group data • Developed and finalized measurement methodologies	• Finalized administrative data collection processes • Refined survey and other data collection processes • Supported implementation of new data input processes for both the demonstration data and the control group data • Finalized measurement methodologies • Agreed on thirty measures/indicators to test twelve hypotheses • Completed draft evaluation design for state review and approval	• Completed final draft evaluation design for state submission to CMS (submitted April 21, 2022) • Received CMS feedback on draft evaluation design (June 21, 2022) • Continued testing of data reporting and refinement of data collection processes	• Revised evaluation design for state review and approval • Completed evaluation design for state submission to CMS (August 22, 2022) • Continued testing of data reporting and refinement of data collection processes • Finalized surveys and recruitment of participants (both provider and participant tools)

AL Community Waiver Program Results to Date

Several factors limit the data reported for the first year of the evaluation, and therefore limit the conclusions which may be drawn at this early stage of the demonstration. These factors include:

- The limited number of CWP enrollees.
- The short enrollment period for many CWP participants combined with the time necessary for the development and implementation of individual HCBS delivery plans. Nearly 70% of CWP enrollment occurred in the final two quarters of the demonstration year, limiting the service delivery experiences of participants and providers. For many measures, attribution of participant outcomes after such a short service delivery period may not provide representative results.
- The CWP data does not reflect a full year of service utilization and may not be a reliable comparison to data from the legacy waivers.
- There is often significant lag time between service delivery and fully adjudicated claims. To date, less than $1 million in spending for CWP services has been reported in the first year of the demonstration, with a significant proportion of this spending attributed to support coordination. Additional review of updated claims reporting in coming months may result in higher numbers, allowing for additional analysis, but the current data do not offer adequate volume for analysis.
- The development and implementation of new and revised survey tools and methodologies. For example, to incorporate National Core Indicators (NCI) data, the state is revising the sampling and data collection methodology starting in calendar year two023.
- Necessary changes in software or data collection infrastructure that were not complete prior to November 1, 2021. For example, changes to the state critical incident reporting system were completed during the first year of the demonstration, so the first full year of available data will be Year two.

Initial results for a small number of evaluation measures do offer some preliminary information about the demonstration; however, these data should be cautiously considered in the context of low numbers of CWP participant service months. Areas showing promise include measures related to:

- **Waiver enrollees' participation in competitive integrated employment** (Measure 4), with 4.4 percent of CWP participants with a completed employment assessment reported to be engaged in qualifying competitive integrated employment, compared to 1.9 percent of legacy waiver participants.
- **Percentage of waiver participants living in residential settings that are not provider owned or controlled** (Measure 9), with 91.9 percent of CWP participants living in a setting that was not provider owned or controlled, compared to 44.4 percent of legacy waiver participants.
- **Waiver participants with plans that include a mix of supports and services that are not paid by Medicaid** (Measures 11 and 12). Nearly 55 percent of participants in the CWP had person-centered plans (PCPs) that included at least one strategy type that was not Medicaid funded in at least three of their five life domains, compared to 42.2 percent of the PCPs assigned to legacy waiver participants. Additionally, 41.8 percent of the strategy types found in CWP participants' PCPs are non-Medicaid funded, compared to 39.8 percent for legacy waiver participant PCPs.

Finally, data for one measure (Measure 13) indicated less than optimal results, with 8.4 percent of CWP enrollees with diverse support strategies in their person-centered plans compared to 11.6 percent of legacy waiver participants.

Year One Evaluation: Challenges

The CWP waiver rolled out gradually in its first year, at a pace that would allow for necessary infrastructure development, capacity building, and effective implementation at the provider and service delivery level. This affected the Year one evaluation in two ways:

- First, enrollment numbers remained modest over the course of the first year, with a total of 180 CWP enrollees. Among these enrollments, 63% occurred during the final two quarters of the demonstration year. For many measures, the enrollment numbers and resulting service utilization data are too low for reliable data analysis. Year two will include the first cohort of participants receiving a full year of CWP services as well as anticipated significant increases in the number of program participants, allowing for more robust and reliable data analysis.
- Second, some data systems and processes needed for the evaluation are in early stages of development. In some cases, needed data were not available, but will be available in Year two as the data infrastructure supporting the waiver continues to grow and evolve.

The systems change that the state is leading via the implementation of this waiver includes the development of new policies, structures, and practices. Along with these new structures, the state is working hard to increase buy in and ensure that staff and providers across the state embrace the changes. The data needed for the evaluation are reliant on implementation and use of the new systems and structures. As these new systems and processes continue to evolve and grow, availability and quality of data will continue to increase.

In some instances, data were not yet available in Year one, lag times for claims data did not allow for timely analysis, and/or the quality of the data was not yet high enough to be reliable. The evaluation team performed some limited testing of administrative data (such as validating information that could be compared to claims data, reviewing open-ended fields for consistency with data reported from fixed value fields, comparing participant enrollment data from different data repositories, and more.) Based upon that testing, some gaps and discrepancies were identified; the state is increasing training and improving reporting processes to improve reliability and accuracy.

As a result, some measures did not have sufficient quality data for meaningful analysis in the first year. Analyses that could be conducted are provided in the table below. For those measures in which analyses could not be conducted, notations related to what was done to prepare for analyses in the next year of the demonstration are provided.

Table 2: Hypotheses, Measures, and Preliminary Observations from Year one

Measure	Description and Objective	Sample Population/Comparison Group	Preliminary Observations (Year One)
Goal 1: Increased access to needed services and supports			
Research Question 1a: To what degree does the CWP result in expanded capacity to serve more individuals and an increased number of annual enrollments of individuals from the ADMH-DDD waiting list? Hypothesis 1a: The CWP will result in expanded capacity to serve individuals and an increased number of annual enrollments of individuals from the ADMH-DDD waiting list.			
M1. Available slots	Total number of funded slots across the CWP and ID and LAH waivers. A key objective of the CWP is to expand the number of eligible individuals with ID receiving HCBS; this measure assesses system capacity	Funded slots across the entire system (ID and LAH waivers and CWP); changes tracked over the duration of the demonstration.	The total number of funded slots for Year one: • CWP: 500 slots • Legacy Waivers: 6,029 slots
M2. Individuals enrolled from the waiting list	Average number of individuals enrolled from the waiting list across the CWP and ID and LAH waivers compared to the average annual number enrolled in the ID and LAH waivers in the prior 10 years A key objective of the CWP is to expand the number of eligible individuals with ID receiving HCBS; this measure assesses enrollment	Enrollees across the entire system (ID and LAH waivers and CWP); changes tracked over the duration of the demonstration	In the 10 years prior to the first year of the evaluation, net enrollments in the legacy waivers averaged 204 per year (excluding 200 enrollments funded by new appropriations during the ten-year period), therefore the waitlist was reduced by an average of 204 people per year. In comparison, there were 264 net enrollments across all waivers in the first year of the evaluation. This included 173 new enrollments in CWP and 91 in legacy waivers (excluding 4 transfers from the LAH waiver to the ID waiver), of which 173 were funded by new appropriations.

Research Question 1b: To what degree does the CWP have lower per-person costs for Medicaid-funded services, inclusive of waiver and state plan services, as compared to ID and LAH waivers? Hypothesis 1b: The CWP will result in lower per-person costs for Medicaid-funded services (HCBS and physical/ behavioral healthcare) compared to the ID and LAH waivers.			
M3. Per-person cost	Mean per-person cost (measured on a member month basis) for individuals in the CWP compared to the mean per-person cost of those in the ID and LAH waivers, and compared to per-person cost prior to the demonstration A key objective of the CWP is to reduce the average per-person cost of Medicaid-funded services allowing expansion of enrollment; this measure assesses cost effectiveness	Individuals in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)	Due to the gradual roll-out of the CWP waiver in Year one, there was less than $1 million in spending for CWP services. Since the CWP data for Year one does not reflect a full year of service utilization, a meaningful comparison legacy waiver cost is not possible. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.

<table>
<tr><th colspan="4">Goal 2: Increased independence of participants</th></tr>
<tr><td colspan="4">Research Question 2a: To what degree does the CWP result in a higher percentage of working-age participants working in competitive integrated employment, and a higher percentage of working-age participants receiving services intended to assist with achieving competitive integrated employment, compared to ID and LAH waiver participants?
Hypothesis 2a: The CWP will result in a higher percentage of working-age individuals working in competitive integrated employment and a higher percentage of working-age individuals receiving services intended to assist with achieving competitive integrated employment compared to individuals in the ID and LAH waivers.</td></tr>
<tr><td>M4. Working-age individuals in competitive integrated employment</td><td>Percentage of individuals ages 19-64 who work in competitive integrated employment during at least one quarter of the evaluation year compared to individuals in the ID and LAH waivers in the CWP counties
A key objective of the CWP is to support enrollees in contributing to their community through participating in competitive integrated employment; this measure assesses the proportion of individuals with employment</td><td>Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers within the CWP counties.</td><td>The table below illustrates the counts of individuals with qualifying CIE (those who are aged 19-64, living in a county in which the CWP is operated, and working in a CIE environment with an average of at least 8 or more hours worked in at least one quarter of the evaluation period according to the participant's documented employment assessment). As the table illustrates, 4.4 percent of the participants with an employment assessment in the CWP had qualifying CIE, compared to 1.9 percent of legacy waiver participants.[12]
<table>
<tr><th></th><th>Legacy Waivers</th><th>CWP Waiver</th></tr>
<tr><td>Ct. w/ CIE</td><td>24</td><td>4</td></tr>
<tr><td>Ct. w/ Emp. Assessment</td><td>1,292</td><td>91</td></tr>
<tr><td>% w/ CIE</td><td>1.9%</td><td>4.4%</td></tr>
</table>
[1]The methodology used to calculate the figures in this table relies upon administrative data queries following defined rules to capture the counts of individuals with qualifying CIE across all programs. A manual review of several CWP employment assessment files identified additional participants not flagged in the administrative data, who would qualify as having CIE based on the multi-point criteria established for this measure. These manual data validation processes were not applied to the data used for the evaluation report due to the need for a consistent approach that can be applied across years and to both CWP and legacy waiver enrollment. Additional quality assurance protocols are being established to improve the data input and accuracy for future reports.</td></tr>
<tr><td>M5. Growth in number of working-age individuals who work in competitive integrated employment</td><td>Change in proportion of individuals ages 19-64 who work in competitive integrated employment from prior year compared to the change in the ID and LAH waivers in the CWP counties
A key objective of the CWP is to support enrollees in contributing to their community through participating in competitive integrated employment; this measure assesses growth in the number of individuals with employment</td><td>Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers within the CWP counties</td><td>This is a baseline data collection year; the measure is not reported for Year one because it requires a comparison of individuals in the CWP with CIE to the results from the prior year.</td></tr>
</table>

M6. Working age individuals who received services intended to assist with achieving competitive integrated employment	Percentage of individuals ages 19-64 who do not work in competitive integrated employment but received at least one paid service intended to assist with achieving competitive integrated employment compared to the percentage in the ID and LAH waivers in the CWP counties A key objective of the CWP is to support enrollees in contributing to their community through participating in competitive integrated employment; this measure assesses the use of services intended to lead to employment	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers within the CWP counties	This measure is not reported for Year one due to the gradual roll-out of the CWP and resulting limitations on CWP participants' use of employment supports during their short enrollment period. The CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.

Research Question 2b: To what degree does the CWP result in higher utilization of self-directed services by CWP participants than for participants in the ID and LAH waivers? Hypothesis 2b: The CWP will result in higher utilization of self-directed services compared to the ID and LAH waivers.			
M7. Utilization of self-direction	Proportion of individuals utilizing self-directed services compared to individuals enrolled in the ID and LAH waivers A key objective of the CWP is to empower individuals through the use of self-direction; this measure assesses the incidence of self-direction	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)	Due to the gradual roll-out of the CWP waiver in Year one, the CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.
M8. Spending delivered through self-directed services	Percentage of total CWP spending delivered through self-directed services compared to the ID and LAH waivers A key objective of the CWP is to empower individuals through the use of self-direction; this measure assesses the volume of services delivered through self-direction	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)	

<table>
<tr><th colspan="4">Goal 3: Increased community integration of participants</th></tr>
<tr><td colspan="4">Research Question 3a: To what degree does the CWP result in a higher percentage of individuals living in, and able to sustain living in, residential settings that are not owned or controlled by providers compared to participants in the ID and LAH waivers?
Hypothesis 3a: The CWP will result in a higher percentage of individuals living in, and able to sustain living in, residential settings that are not owned or controlled by providers compared to individuals in the ID and LAH waivers.</td></tr>
<tr><td>M9. Individuals living in settings that are not provider owned or controlled</td><td>Percentage of individuals living in residential settings that are not provider owned or controlled, compared to the percentage in the ID and LAH waivers
A key objective of the CWP is to support individuals in the most integrated residential settings; this measure assesses placement levels</td><td>Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)</td><td>In the first year of the evaluation, the proportion of participants enrolled in the CWP waiver who lived in a setting that was not provider owned or controlled was more than double the proportion of participants in the legacy waivers.
The table below reports the number of participants living in each residential category, then calculates the proportion living in a setting that is not provider owned or controlled. As the table illustrates, 92.3 percent of CWP participants lived in a setting that was not provider owned or controlled, compared to 44.6 percent in the legacy waivers.
<table>
<tr><th>Setting</th><th>Legacy Waivers</th><th>CWP Waiver</th></tr>
<tr><td>Not Provider Owned/ Controlled</td><td>2,258</td><td>156</td></tr>
<tr><td>Provider Owned/ Controlled</td><td>2,807</td><td>13</td></tr>
<tr><td>Proportion Not Provider Owned/Controlled</td><td>44.6%</td><td>92.3%</td></tr>
</table></td></tr>
<tr><td>M10. Individuals who continue to live in setting that are not provider owned or controlled</td><td>Percentage of individuals living in residential settings that are not provider owned or controlled at the beginning of the evaluation year who remain in a setting that is not provided owned or controlled at the end of the evaluation year, compared to the percentage in the ID and LAH waivers
A key objective of the CWP is to support individuals in the most integrated residential settings; this measure assesses the maintenance of placements</td><td>Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)</td><td>This measure is not reported because it requires a comparison of CWP participants' residential setting at the beginning of the evaluation year and the majority of CWP participants in Year one was not enrolled at the beginning of the evaluation year.</td></tr>
</table>

<table>
<tr><td colspan="4">Research Question 3b: To what degree does the CWP result in increased identification and use of the full range of services and supports (waiver and non-waiver) compared to the identification and use of services and supports in the ID and LAH waivers?
Hypothesis 3b: The Community Waiver Program will result in increased utilization of the full range of waiver services and supports available, and a higher incidence of non-waiver supports and services being identified and included in person-centered plans to address individual goals and outcomes compared to the ID and LAH waivers.</td></tr>
<tr><td>M11. Participants with non-Medicaid supports in their plans</td><td>Percent of individuals whose person-centered plan includes at least one support strategy type that does not rely on Medicaid funded services in at least three of five life domains, compared to the plans for individuals enrolled in the ID and LAH waivers
A key objective of the CWP is to increase the utilization of the full range of community services and supports available including more individualized and integrated options; this measure assesses the use of non-waiver funded services</td><td>Individuals in the CWP; comparison made to individuals in the ID and LAH waivers</td><td>Nearly 55 percent of participants in the CWP had person-centered plans (PCPs) that included at least one strategy type that was not Medicaid funded in at least three of the five life domains, compared to just over 42 percent of the PCPs for legacy waiver participants.
The table below reports the number of participants with at least one non-Medicaid-funded strategy in at least three life domains, the total number of documented PCPs, and the proportion of PCPs with at least one non-Medicaid-funded strategy in at least three of the five life domains.<table><tr><td></td><td>Legacy Waivers</td><td>CWP Waiver</td></tr><tr><td>Total PCPs</td><td>4,576</td><td>95</td></tr><tr><td>% of PCPs with Three or More Non-Medicaid Funded Strategies</td><td>42.2%</td><td>54.7%</td></tr></table></td></tr>
<tr><td>M12. Support strategies not paid by Medicaid</td><td>Average percentage of non-Medicaid HCBS support strategy types in person-centered plans compared to ID and LAH waivers
A key objective of the CWP is to incorporate into person-centered planning the full range of services and supports available including more individualized and integrated services; this measure assesses the magnitude of the planned use of non-waiver services</td><td>Individuals in the CWP; comparison made to individuals in the ID and LAH waivers</td><td>As detailed in the following table, 41.8 percent of the strategy types found in CWP participants' PCPs are non-Medicaid funded, compared to 39.8 percent of the strategy types found in legacy waiver participant PCPs.<table><tr><td></td><td>Legacy Waivers</td><td>CWP Waiver</td></tr><tr><td>Total Strategies</td><td>37,067</td><td>1,048</td></tr><tr><td>% of Strategies That are Non-Medicaid Funded</td><td>39.8%</td><td>41.8%</td></tr></table></td></tr>
<tr><td>M13. Individuals with diverse support strategies in</td><td>Percentage of individuals whose person-centered plans include multiple support strategy types in each of the five life domains as compared to the person-centered</td><td>Individuals in the CWP; comparison made to individuals in the ID and LAH waivers (measured both within the counties</td><td>The table below illustrates that 8.4 percent of CWP participants' PCPs included multiple strategy types (including both Medicaid and non-Medicaid funded strategies), which was slightly lower than</td></tr>
</table>

<table>
<tr>
<td>their person-centered plan</td>
<td>plans of individuals in the ID and LAH waivers
A key goal of the CWP is to increase the utilization of the full range of services and supports available including more individualized and integrated services; this measure assesses the use of multiple strategies to address individuals' needs</td>
<td>where the demonstration is available and statewide)</td>
<td>the 11.6 percent of legacy-waiver participants' PCPs with multiple strategy types.
<table>
<tr><th></th><th>Legacy Waivers</th><th>CWP Waiver</th></tr>
<tr><td>Total PCPs</td><td>4,576</td><td>95</td></tr>
<tr><td>Count of PCPs with Multiple Strategy Types</td><td>531</td><td>8</td></tr>
<tr><td>% of PCPs with Multiple Strategy Types</td><td>11.6%</td><td>8.4%</td></tr>
</table>
</td>
</tr>
<tr>
<td>M14. Allocation of spending</td>
<td>Percentage of annual spending in each service category grouping (e.g., residential, employment) compared to the distribution of spending in the ID and LAH waivers
A key objective of the CWP is to increase the utilization of the full range of paid and unpaid services and supports available including more individualized and integrated services; this measure assesses how Medicaid funds are allocated across different service categories</td>
<td>Individuals in the CWP; comparison made to individuals in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)</td>
<td>Due to the gradual roll-out of the CWP waiver in Year one, there was less than $1 million in spending for CWP services. The CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.</td>
</tr>
<tr>
<td>M15. Service utilization</td>
<td>Percentage of individuals utilizing at least one unit of service within a service category grouping in the evaluation year compared to the ID and LAH waivers
A key objective of the CWP is to increase the utilization of the full range of paid and unpaid services and supports available including more individualized and integrated services; this measure assesses the use of categories of services</td>
<td>Individuals in the CWP; comparison made to individuals in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)</td>
<td>Due to the gradual roll-out of the CWP waiver in Year one, there was less than $1 million in spending (and related service utilization) for CWP services. The CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.</td>
</tr>
</table>

Goal 4: Prevention of escalation of needs of participants			
Research Question 4a: To what degree does the CWP result in a lower proportion of crises among CWP participants than among ID and LAH participants, and a lower proportion of emergency enrollments as a result of crises among individuals on the waiver waiting list in the counties where the CWP is available as compared to the rest of the state? Hypothesis 4a: The CWP will result in a lower proportion of crises among individuals in the CWP compared to those in the ID and LAH waivers, and a lower proportion of emergency enrollments as a result of crises among individuals on the waiver waiting list in the counties where the CWP is available as compared to the rest of the state.			
M16. Individuals who experience a documented crisis	Percentage of individuals who experience a documented crisis compared to the percentage in the ID and LAH waivers A key objective of the CWP is to reduce the number of crises that individuals experience; this measure assesses incidence of crises	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)	This measure is not reported for Year one because development was required of the information system infrastructure to report the necessary data. The new system was fully implemented as of October 1, 2022, so this measure will be reported going forward.
M17. Crises experienced by individuals	Number of crises per individual A key objective of the CWP is to reduce the number of crises that individuals experience; this measure assesses the recurrence of crises	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers (measured both within the counties where the demonstration is available and statewide)	This measure is not reported for Year one because development was required of the information system infrastructure to report the necessary data. The new system was fully implemented as of October 1, 2022, so this measure will be reported going forward.
M18. Emergency enrollments due to crises	Percentage of individuals on the waiver waitlist in counties where the CWP operates who experience a documented crisis resulting in emergency enrollment compared to the remainder of the state where CWP does not operate A key objective of the CWP is to reduce the number of crises that individuals experience; this measure assesses the extent to which crises result in emergency enrollments	Individuals on waitlist in CWP counties; comparisons made to individuals on waitlist in remainder of counties where CWP is not available	This measure is not reported for Year one because development was required of the information system infrastructure to report the necessary data. The new system was fully implemented as of October 1, 2022, so this measure will be reported going forward.

Research Question 4b: To what degree does the CWP prevent an escalation of needs that would result in 1915(c) eligibility and enrollment among CWP Group 5 participants? Hypothesis 4b: The majority of CWP participants who do not meet an institutional level of care will not experience an escalation of needs resulting in enrollment in a 1915(c) group.			
M19. Individuals who remain in Group 5	Percentage of individuals in Group 5 who remain in Group 5 during the evaluation period. A key objective of the CWP is to prevent escalation of needs for individuals who do not yet require an institutional level of care; this measure assesses the maintenance of enrollment in the non-institutional level of care group	Individuals enrolled in Group 5; changes tracked over the duration of the demonstration	This measure is not reported for Year one as there were no participants enrolled in Group 5.

Goal 5: Increased stability and quality of providers			
Research Question 5a: To what degree does the CWP result in higher average wages and lower average turnover rates for direct support workers (DSWs) employed through self-direction compared to DSWs employed by provider agencies? Hypothesis 5a: The CWP will result in higher average wages and lower average turnover rates for direct support workers employed through a self-directed model compared to DSWs employed by provider agencies.			
M20. Average hourly wages of direct support workers	Average hourly wage for DSWs delivering self-directed services compared to agency employed DSWs A key objective of the CWP is to support the DSW workforce through the increased use of self-direction; this measure assesses wages	DSWs employed through a self-directed model in the CWP; comparison made to agency-employed DSWs in the CWP	Due to the gradual roll-out of the CWP waiver in Year one, he CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.
M21. Average turnover rates of direct support workers (DSWs)	Average turnover rate for DSWs delivering self-directed services compared to agency employed DSWs A key objective of the CWP is to support the DSW workforce through the increased use of self-direction; this measure assess turnover	DSWs employed through a self-directed model in the CWP; comparison made to agency-employed DSWs in the CWP	Due to the gradual roll-out of the CWP waiver in Year one, the CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.
Research Question 5b: To what degree does the CWP result in participating provider agencies reporting greater organizational stability as a result of their CWP participation, and greater stability as compared to providers participating only in the ID and LAH waivers? Hypothesis 5b: The Community Waiver Program will result in participating provider agencies reporting greater organizational stability compared to ID and LAH waiver providers.			
M22. Self-reported provider agency stability	Percent of CWP providers that self-report greater organizational stability A key objective of the CWP is to increase organizational stability for participating providers	Agencies enrolled in the CWP; comparison made to agencies that provide ID and LAH waiver services, but not CWP services	This measure is not reported for Year one due to the survey data being limited as a result of the gradual CWP roll out and short periods of service delivery in Year one. The provider survey will be readministered in Year two for the first reported year of data.
M23. Provider stability indicators	Percent of providers demonstrating improvement in organizational stability indicators compared to ID and LAH waiver providers A key objective of the CWP is to increase organizational stability for participating providers	Agencies enrolled in the CWP; comparison made to agencies that provide ID and LAH waiver services, but not CWP services	This measure is not reported for Year one due to the survey data being limited as a result of the gradual CWP roll out and short periods of service delivery in Year one. The provider survey will be readministered in Year two for the first reported year of data.

Research Question 5c: To what degree does the CWP result in higher performance by providers on service delivery quality measures as compared to providers operating only in the ID and LAH programs? Hypothesis 5c: The CWP will result in higher performance by providers on service delivery quality measures compared to providers serving only the ID and LAH waivers.			
M24. Independent accreditation	Percentage of CWP providers who have achieved or maintained accreditation status from a nationally recognized accreditation body compared to ID and LAH waiver providers A key objective of the CWP is to increase the quality of services; this measure assesses agencies who have been independently accredited	Agencies enrolled in the CWP; comparison made to agencies that provide ID and LAH waiver services, but not CWP services	This measure is not reported for Year one due to the development of a new survey and strategy for administering the survey. Results for Year one will be available in the second quarter of Year two.
M25. Individual experience	Percentage of individuals enrolled in the CWP who report positive outcomes on certain NCI questions compared to individuals enrolled in the ID and LAH waivers A key objective of the CWP is to increase the quality of services; this measure assesses individuals' perspectives on service quality	Individuals enrolled in the CWP and surveyed in the NCI; comparison made to individuals enrolled in the ID and LAH waivers and surveyed in the NCI	To accommodate the evaluation needs, the state is changing the planned sampling process for NCI surveys for CY2023 to ensure adequate participation from CWP enrollees. As a result, Year two of the demonstration will be the first possible reporting year for this measure.
M26. Critical Incidents	Number of critical incidents attributable to CWP providers in relation to total enrolled individuals compared to ID and LAH waiver providers A key objective of the CWP is to increase the quality of services; this measure assesses the number of critical incidents	Providers enrolled in CWP as compared to providers enrolled in only ID and LAH Waivers	This measure is not reported for Year one because development was required of the information system infrastructure to report the necessary data. The new system was fully implemented as of October 1, 2022, so this measure will be reported going forward.

Research Question 5d: To what degree does the CWP result in higher retention of Support Coordinators, increased continuity of care and increased levels of satisfaction among individuals and families compared to the ID and LAH waivers? Hypothesis 5d: The CWP will result in lower turnover of Support Coordinators, increased continuity of care, and higher rates of satisfaction with Support Coordination compared to the ID and LAH waivers.			
M27. Turnover rates for Support Coordinators	The turnover rate for Support Coordinators in the CWP compared to those in the ID and LAH waivers A key objective of the CWP is to increase the quality of support coordination services; this measure assesses turnover	Support Coordinators in the CWP program; comparison made to Support Coordinators in the ID and LAH waivers	Due to the gradual roll-out of the CWP waiver in Year one, the CWP data for Year one does not reflect a full year of service utilization and may not be a reliable comparison to the data from the legacy waivers. HMA anticipates Year two data will be more complete and offer a valid and reliable comparison.
M28. Continuity of Support Coordinators	Percentage of CWP participants who maintain the same Support Coordinator during the evaluation year compared to ID and LAH waivers A key objective of the CWP is to increase the quality of support coordination services; this measure assesses consistency of relationships between individuals and Support Coordinators	Enrollees in the CWP; comparison made to enrollees in the ID and LAH waivers	This measure is not reported since Year one would be the baseline year of comparison for the CWP group.
M29. Individual satisfaction with support coordination services	Average rate of individuals' satisfaction with support coordination services compared to satisfaction of individuals in the ID and LAH waivers A key objective of the CWP is to increase the quality of support coordination services; this measure assesses individuals' satisfaction with support coordination services	Surveying individuals in the CWP; comparison made to surveyed individuals in the ID and LAH waivers.	This measure is not reported for Year one due to the development of a new survey and strategy for administering the survey. Results for Year one will be available in the second quarter of Year two.
M30. Family/guardian satisfaction with support coordination services	Average rate of family/guardian satisfaction with support coordination services compared to satisfaction of families/guardians of individuals in the ID and LAH waivers A key objective of the CWP is to increase the quality of support coordination services; this measure assesses families'/guardians' satisfaction with support coordination services	Surveying families/guardians in the CWP; comparison made to surveyed families/ guardians in the ID and LAH waivers.	This measure is not reported for Year one due to the development of a new survey and strategy for administering the survey. Results for Year one will be available in the second quarter of Year two.