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CHAPTER FORTY-FOUR

HOME AND COMMUNITY-BASED SERVICES
FOR THE ALABAMA COMMUNITY TRANSITION (ACT) WAIVER

Chapter 44. Home and Community-Based Services (HCBS) for the Alabama Community Transition (ACT) Waiver

Rule No. 560-X-44-.01. Authority and Purpose

(1) Home and Community-Based Services for the ACT Waiver are provided by the Alabama Medicaid Agency to disabled individuals who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of five years and for five year periods thereafter upon renewal of the waiver by the Centers for Medicare and Medicaid Services.

(2) The purpose of the ACT Waiver is to enable individuals, who currently reside in a nursing facility, the opportunity to transition out of the facility and receive home and community based services in the community. A second target population would be individuals currently being served on one of Alabama's other HCBS waivers whose condition is such that their current waiver is not meeting their needs and admission to an institution is eminent if the ACT Waiver were not an option to better serve their needs.

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR 441, Subpart G.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.02. Eligibility

(1) Financial eligibility is limited to those individuals receiving SSI, individuals receiving State Supplementation, SSI related protected groups deemed to be eligible for SSI/Medicaid, and Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

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

(3) The Alabama Medicaid Agency or its operating agency, the Alabama Department of Rehabilitation Services (ADRS), acting on Medicaid's behalf may deny home and community-based services if:

(a) If it is determined that an individual's health and safety is at risk in the community;

(b) The cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility;

(c) The individual does not cooperate with a provider in the provision of services;

(d) The individual does not meet the goals and objectives of being on the waiver program.

(4) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by the Centers for Medicare and Medicaid Services.

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based ACT Waiver
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.03. Operating Agencies

The Home and Community-Based Services ACT Waiver is a cooperative effort between the Alabama Medicaid Agency and the ADRS.

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: The Home and Community-Based Services ACT Waiver
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.04. Covered Services

(1) Community Case Management Services

(a) Community Case Management is a comprehensive system of providing services which will assist waiver recipients in gaining needed waiver and other state plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Community Case Management services may be used to locate, coordinate, and monitor necessary and appropriate services. Community Case Management activities will also be used to assist in the transition of an individual from an institutional setting to the community. Community Case Management activities to facilitate transition are limited to a maximum of 180 days prior to discharge into the community.

(b) Case managers are responsible for Plan of Care development and ongoing monitoring of the provision of waiver services and non-waiver services included in the recipient's Plan of Care.

(c) Case management will be provided by a case manager employed by or under contract with the ADRS.

(2) Personal Care Services

(a) Personal care services are services that provide assistance with eating, bathing, dressing, personal hygiene and activities of daily living. Services may include assistance with preparation of meals but do not include the cost of meals themselves. When specified in the Plan of Care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

(b) Personal care services will be provided by individuals employed by a certified Home Health Agency or other health care agencies approved by the

Commissioner of the Alabama Medicaid Agency and supervised by a case manager. Persons providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal care services may be provided by family members or friends only if a lack of other qualified providers in applicable remote areas exists.

(d) Services provided to each client are dependent on individual need as set forth in the client's Plan of Care.

(3) Home Modifications (Environmental Accessibility Adaptations - EAA)

(a) Environmental accessibility adaptations provide those physical adaptations to the home required by the individual's Plan of Care which are necessary to ensure the health, welfare, and safety of the individual or which enable the individual to function with greater independence in the home and without which the individual would require institutionalization.

(b) Adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home or permanent adaptations to rental property are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

(c) Environmental accessibility adaptations will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building codes.

(d) Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee for prior authorization and must be listed on the client's Plan of Care. Any expenditure in excess of the maximum allowed amount must be approved by the State Coordinator and the Medicaid designated personnel.

(e) The service also may be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(f) Limits on Home Modifications (EAA) are $5,000 per waiver participant for the entire stay on the waiver.

(4) Personal Emergency Response System

(a) Personal Emergency Response System (PERS) is an electronic service which enables certain high-risk patients to secure help in the event of an emergency. The client may also wear a portable "help" button which allows the client flexibility in mobility. The system is connected to a patient's phone and programmed to signal a response center once a patient's "help" button is activated.

(b) PERS must be provided by trained professionals. The PERS staff must complete a two-week training period for familiarization with the monitoring system and proper protocol to provide appropriate response action.

(c) Initial setup and installation of PERS must be on the individual's Plan of Care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

(d) The service also may be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(5) Medical Supplies

(a) Medical supplies include: devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency and the ADRS.

(c) Medical supplies service shall not exceed $1,800.00 annually per recipient.

(6) Assistive Technology

(a) Assistive technology includes devices, pieces of equipment or products that are modified or customized which are used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include evaluation of need, acquisition, selection, design, fitting, customizing, adaptation, application, etc. This service must be listed on the individual's Plan of Care. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

(b) The service must be medically necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the ACT Waiver. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate. All items shall meet applicable standards of manufacture, design and installation.

(c) Assistive technology and transitional assistive technology services must be prior authorized and approved by the Alabama Medicaid Agency, or its designee and must be listed on the client's Plan of Care.

(d) Assistive technology services will be provided by licensed individuals or businesses capable of supplying the needed equipment and/or supplies. Assistive technology must be approved by the Alabama Medicaid Agency and must be listed in the individual's Plan of Care.

(e) Providers of this service will be those who meet provider qualifications and who have a signed provider agreement with the ADRS. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

(f) Assistive Technology has a cumulative limit of $15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(g) The service may also be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(7) Assistive Technology Repairs

(a) Assistive technology repairs will provide for the repair of devices, equipment, or products that were previously purchased by the Alabama Medicaid Agency for the recipient. Repairs include replacement of parts or batteries to allow the equipment to operate.

(b) The provider should be responsible for replacement or repair of the equipment or any part thereof that is found to be non-functional because of faulty material or workmanship within the guarantee of the manufacturer without any charge to the recipient or the ADRS. Only repairs outside the warranty period will be eligible for reimbursement.

(c) Businesses providing this service will possess a business license and also be required to give a guarantee on work performed.

(d) This service must be listed on the recipient Plan of Care before being provided.

(e) Assistive Technology has a cumulative limit of $15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(8) Evaluation for Assistive Technology

(a) Evaluation for assistive technology will provide evaluations and determinations of a client's needs for equipment prescribed by a physician to promote health, safety, and prevent institutionalization or to assist an individual to transition from an institution to the ACT Waiver. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

(b) The individual providing evaluation must be a physical therapist licensed to do business in the state of Alabama and enrolled as a provider with the ADRS. The physical therapist should not have any financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of assistive technology equipment/devices.

(c) A written copy of the physical therapist's evaluation must accompany the prior authorization request and a copy must be kept in the recipient's file. This service must be listed on the recipient's Plan of Care before being provided.

(d) Assistive Technology has a cumulative limit of $15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(9) Personal Assistance/Attendant Service

(a) Personal Assistance/Attendant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual if that person did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform everyday activities. This

service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those seeking competitive employment either in their home or in an integrated work setting.

(b) Personal Assistance/Attendant Services will be provided by a personal care attendant under the supervision of a registered nurse who meets the Personal Assistance/Attendant Service staffing requirements. Individuals providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal Assistance/Attendant Services may be provided by family members or friends only if there is a lack of other qualified providers in remote areas.

(10) Adult Day Health Services

(a) Adult Day Health Service provides social and health care in a community facility approved to provide such care. Health education, self-care training, therapeutic activities, and health screening shall be included in the program.

(b) Adult Day Health Service is provided by facilities that meet the minimum standards for Adult Day Health Centers. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health Services meets the prescribed standards.

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

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

(11) Respite Care

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

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

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

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

(12) Adult Companion Services

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

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

(b) Other service definitions include accompanying a client to a medical appointment, grocery shopping or picking up prescription medications. The companion service is available to only those clients living alone. Companion services cannot be provided at the same time as other approved waiver services with the exception of case management services. Companion services must not exceed four hours daily.

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

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

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the care plan shall be recovered.

(13) Home Delivered Meals

(a) Home delivered meals are provided to an eligible individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

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

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

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

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

(f) All menus must be reviewed and approved by a Registered Dietitian with licensure to practice in the State of Alabama.

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

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

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

(14) Homemaker Services.

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

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

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

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

(15) Skilled Nursing

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

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

(16) Transitional Assistance Service

(a) Transitional Assistance service is a service that will assist with the expense of transitioning from a nursing facility to the community.

(b) Examples of expenses may include: deposits for utilities, pest eradication, one-time cleaning prior to occupancy, essential household furnishings, and moving expenses.

(c) Transitional Assistance Service cannot exceed $1,500.

(d) This service may be provided to the client prior to transition from the institution, the service should not be billed until the first day the client is active on the waiver.

ACT Waiver services provided to assist an individual to transition to the community shall be billed once the client has been successfully transitioned to the community. If the

individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate and not the service rate.

Author: Mattie M. Jackson, Program Manager, LTC Program Management Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based ACT Waiver.
History: New Rule: Filed February 10, 2012; effective March 16, 2012. Amended: Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-44-.05. Costs for Services

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

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based ACT Waiver.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.06. Application Process

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

(2) For institutional residents residing in a facility for at least 90 days who are transitioning into the community, the case manager should thoroughly review referrals and intake information. This process will take place during the 180 consecutive day transition period.

(3) An initial assessment will be completed by the case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the operating agency, ADRS, for approval.

(4) The case manager, in conjunction with the applicant's physician, client and/or caregiver will develop a Plan of Care. The Plan of Care will include objectives, services, provider of services, and frequency of service. Changes to the original Plan of Care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's Plan of Care which is subject to the review of the Alabama Medicaid Agency. The Plan of Care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

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

(6) The Alabama Medicaid Agency requires the providers to submit an application in order to document dates of service provision to long term care recipients.

(a) The long term care software maintains these dates of service.

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

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

(7) The ADRS is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the ACT Waiver.

(8) The Alabama Medicaid Agency will provide to ADRS the approved level of care criteria and policies and procedures governing the level of care determination process.

(9) The ADRS will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

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

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

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

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

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

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

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the ACT Waiver.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.07. Fair Hearings

(1) An individual whose application to the waiver program is denied or waiver participants whose services are terminated, suspended, or reduced based on Rule No. 560-X-44-.02, may request an appeal in accordance with 42 CFR Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code, as modified by the below provisions.

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

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

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

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

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

Author: Mattie M. Jackson, Program Manager, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431, Subpart E.
History: New Rule: Filed February 10, 2012; effective March 16, 2012. Amended: Filed June 12, 2012; effective July 17, 2012.

Rule No. 560-X-44-.08. Payment Methodology for Covered Services

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

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, a claim with dates of service of

May 15, 2011 to June 15, 2011 is not allowed. If the submitted claim covers any dates of service which were covered in a previously paid claim, the claim will be rejected.

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

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

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

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

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

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.09. Confidentiality

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

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431.306, Subpart F—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.10. Records

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

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

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

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

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.11. Service Providers

The Home and Community-Based Services ACT Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services.

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.

Rule No. 560-X-44-.12. Enrollment.

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

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

(3) For unique goods and services, or one time purchases, a provider may enroll with ADRS at ADRS' discretion. If a provider enrolls directly with ADRS, ADRS will be solely responsible for the legitimacy and performance of the provider.

Author: Ginger Wettingfeld, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed February 10, 2012; effective March 16, 2012.