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CHAPTER FIFTY-TWO

HOME AND COMMUNITY-BASED LIVING AT HOME (LH) WAIVER FOR PERSONS WITH INTELLICTUAL DISABILITIES

Chapter 52 - Home and Community-Based Living at Home (LH) Waiver for persons with Intellectual Disabilities

Rule No. 560-X-52-.01. Authority and Purpose.

(1) Home and community-based services for individuals with intellectual disabilities are provided by the Alabama Medicaid Agency to persons who are Medicaid-eligible under the waiver and who would, but for the provision of such services, require the level of care available in an intermediate care facility (ICF/IID) for individuals with intellectual disabilities. These services are provided through a Medicaid waiver under provisions of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act, for an initial period of three years and renewal periods of five years.

(2) Home and community-based services covered in this waiver are In-Home Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Supported Employment Emergency Transportation, Occupational Therapy, Speech and Language Therapy, Physical Therapy, Behavior Therapy, Respite Care, Personal Care Services, Personal Care Transportation, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Skilled Nursing, Community Specialist Services, Individual Directed Goods and Services, and Crisis Intervention. These services provide assistance necessary to ensure optimal functioning of individuals with intellectual disabilities.

(3) The Home and Community Based Living at Home Waiver is administered through a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and is restricted to individuals with a diagnosis of an intellectual disability, ages 3 and above, and those not residing in a group home situation. Priority access to the Living at Home Waiver shall be given to individuals on a verified waiting list.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
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Rule No. 560-X-52-.02. Description of Services.

Home and community-based services are defined as Title XIX Medicaid-funded services provided to individuals with intellectual disabilities who, without these services, would require services in an ICF/IID. These services will provide health, social, and related support needed to ensure optimal functioning of an individual with an intellectual disability within a community setting. The operating agency may provide or subcontract

for any services provided in this waiver. To qualify for Medicaid reimbursement each individual service must be necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as waiver services. The specific services available as part of home and community-based services are:

(1) In-Home Residential Habilitation

(a) In-Home residential habilitation services provide care, supervision, and skills training in ADLs, home management and community integration.

(b) In-Home residential habilitation includes the following:

1. Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (i.e. moving a chair, substituting velcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

2. Habilitation supplies and equipment; and

3. Transportation costs to transport individuals to day programs, social events or community activities, when public transportation or transportation covered under the Medicaid State Plan is not available, accessible or desirable due to the functional limitations of the client, will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

(c) Residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities.

(d) A unit of service is one hour. The place of service will primarily be the person's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

(e) In-Home residential habilitation goals must relate to identified, planned goals. Training and supervision of staff by a Qualified Intellectual Disabilities Professional (QIDP) shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements must be met prior to the staff beginning work. Additional training to specifically address and further the goals in the individual's plan may occur on the job. Consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

(f) In-Home residential habilitation excludes the following:

1. Services, directly or indirectly, provided by a member of the individual's immediate family;

2. Routine care and supervision which would be expected to be provided by a family member;

3. Activities or supervision for which a payment is made by a source other than Medicaid; and

4. Room and board costs.

(g) Providers of residential habilitation must be certified by the Department of Mental Health.

(2) Day Habilitation

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

(b) The provider for Day Habilitation services can be reimbursed based on eight levels of services.

(c) This service offers another mechanism by which a participant can attend day habilitation part of a day, and work in a supported employment setting with an individual job coach during the same day.

(d) Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client, will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health.

(3) Prevocational Services

(a) Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(b) When compensated, individuals are paid at less than 50 percent of the minimum wage.

(c) Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

(d) Providers of prevocational services must be certified by the Department of Mental Health.

(e) Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401[16] and [17]).

(4) Supported Employment

(a) Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(b) Supported employment is conducted in a variety of settings, particularly, work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

(c) When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities. Payment for the supervisory activities rendered as a normal part of the business setting will not be made.

(d) Supported employment may be provided under the Individual Job Coach and Job Developer services to further encourage full integration of waiver participants into worksites where individuals without disabilities are employed.

(e) Supported employment maybe provided in small groups. Supported Employment Small Group services are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities.

(f) Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

(g) Medicaid reimbursement shall not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

(h) Payments for vocational training that is not directly related to an individual's supported employment program.

(i) Transportation will be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

(j) Supported Employment Emergency Transportation service can be authorized, under special circumstances, intended to be limited in scope, duration, and not to exceed the annual cap.

(k) Providers of supported employment must be certified by the Department of Mental Health.

(5) Occupational Therapy

(a) Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. Occupational therapy services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning.

(b) Therapists may also provide consultation and training to staff or caregivers (such as client's family and /or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(c) Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed by the hour. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(d) Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered.

(e) Occupational Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

(6) Speech and Language Therapy

(a) Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.).

(b) These services may include:

1. Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

2. Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' habilitation programs; and

3. Treatment services as an extension of the evaluation process that include:

(i) Consulting with others working with the individual for speech education and improvement,

(ii) Designing specialized programs for developing an individual's communication skills comprehension and expression.

(c) Therapists may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(d) Speech and language therapy services must be listed on the care plan and prescribed by a physician. The need for service must be documented in the case record. Services shall be provided and billed by the hour. Speech and language therapy

is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered.

(f) Speech and Language Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

(7) Physical Therapy

(a) Physical therapy is physician-prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical therapy services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and

2. Prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

(b) Therapists may also provide consultation and training to staff or caregivers (such as client's family and/or foster family).

(c) Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(d) Documentation in the case record must justify the need for this service. Services must be listed on the care plan and be provided and billed by the hour. Physical therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered.

(f) Physical Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

(8) Behavior Therapy

(a) Behavior Therapy Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers, and habilitation services providers. Behavior

therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

(b) A behavior management plan may only be used after positive behavioral approaches have been tried, and its continued use must be reviewed and re-justified in the case record every thirty (30) days. The unit of service is 15 minutes.

(c) The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

(d) The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

(e) Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

(f) The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

(g) Behavior Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

(9) Respite Care

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

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

(c) Some consumers are institutionalized because their community supports become exhausted, or because they are unsure of how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without

additional intervention and supports. Planning will be made for alternate residential supports if return is not possible.

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

(e) Out-of-home respite care may be provided in a certified group home or ICF/IID. In addition, if the recipient is less than 21 years of age, out-of-home respite care may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out-of-home respite, no additional Medicaid reimbursement will be made for other services in the institution.

(f) Medicaid reimbursement shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

(10) Personal Care Services

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

(b) Personal care under the Living at Home Waiver may also include general supervision and protective oversight reasonable to the accomplishment of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual.

(c) A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Developmental Disabilities and be subject to review by the Single State Agency for Medicaid.

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

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

(f) When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily

provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

(g) There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. This would preclude personal care being provided in, for instance, a day habilitation or respite setting where payment would already be made for the same services. Payment is for an hour of service, not including worker's time of travel to and from the place of work.

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

(i) Personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. This service must be billed under a separate code to distinguish it from other personal care activities.

(j) Personal Care may be self-directed to allow participants and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers.

(11) Personal Care Transportation

(a) Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

(b) The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

(c) Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

(12) Environmental Accessibility Adaptations

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

(b) Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

(d) Total costs of environmental accessibility adaptations shall not exceed $5,000 per waiver year, per individual.

(13) Specialized Medical Supplies

(a) Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

(b) These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacturer, design, and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Mental Health. Medical supplies are limited to a maximum of 1,800.00 per recipient per year. The operating agency must maintain documentation of items purchased for the recipient.

(14) Specialized Medical Equipment

(a) Specialized medical equipment includes devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. Invoices for medical equipment must be

maintained in the case record. This service must be necessary to prevent institutionalization of the recipient. All items shall meet applicable standards of manufacturer, design, and installation. Costs are limited to 5,000 per recipient, per year.

(15) Skilled Nursing

(a) Skilled nursing services are services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

(b) Skilled nursing services consist of nursing procedures that meet the person's health needs as ordered by a physician.

(c) Skilled nursing services will be billed by the hour. There is no restriction on the place of service.

(d) This service may also be self-directed when provided to a participant or family which is self-directing personal care services. Service includes training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker.

(16) Community Specialist Services

(a) Community Specialist Services are professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not.

(b) The provider must meet QIDP qualifications and be free of any conflict of interest with other providers serving the consumer. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

(c) Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

(d) The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver.

(e) The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory.

(f) The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client's needs and condition.

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

(h) This service may be self-directed for participants who self-direct Personal Care. The community specialist will inform and consult, intervene, and trouble shoot any problems the participant may have with self-directing their services.

(i) This service is a cost effective and necessary alternative to placement in an ICF-IID. A unit of service is one hour.

(17) Crisis Intervention

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

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

(c) Crisis intervention will respond intensively to resolve crisis situations and prevent the dislocation of the person at risk such as individuals with intellectual disabilities who are occasionally at risk of being moved from their residences to institutional settings because of family's inability to cope with short term, intense crisis situations. This service is a cost effective alternative to placement in an ICF-IID.

(d) Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

(e) Crisis intervention services require two levels of staff, professional and technician.

(f) A unit of service is one hour and must be provided by the waiver planning team, directed by a graduate psychologist or licensed social worker.

(g) When the need for this service arises, the service will be added to the plan of care for the person.

(h) A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided.

(i) All crisis intervention services shall be approved by the regional community service office of the DMH prior to the service being initiated.

(j) Crisis intervention services will not count against the $25,000 per person per year cap in the waiver, since the need for the service cannot accurately be predicted and planned for ahead of time.

(k) Specific crisis intervention service components may include the following:

1. Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;

2. Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;

3. Developing and writing an intervention plan;

4. Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;

5. Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;

6. Assisting the consumer with self-care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and

7. Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

(18) Individual Directed Goods and Services

(a) Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community and meet the following requirements: the item or service would decrease the need for other Medicaid service; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; the item or service is not illegal or otherwise prohibited by Federal and State statutes and regulations, and the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

(b) The limit on the amount of Goods and Services that can be purchased is determined individually based on the balance of the individual's saving account at the time of the request which is maintained by the Financial Management Services Agency, but not to exceed $1000 annually.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
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Rule No. 560-X-52-.03 Eligibility.
Medical eligibility is limited to those individuals who meet the ICF/IID facility level of care. No waiver services will be provided to a recipient residing in an institutional facility, or who has a primary diagnosis of mental illness, or whose health and safety is at risk in the community. Thus services will be available to individuals with intellectual disabilities who would be eligible for institutional services under 42 CFR §435.217.

Financial eligibility is limited to the following individuals:

- Individuals receiving SSI.
- SSI related protected groups deemed to be eligible for SSI/Medicaid.
- Medicaid for Low Income Families (MLIF).
- Federal and State adoption subsidy individuals.
- Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

ID persons who meet categorical (including 42 CFR 435.120) medical and/or social requirements for Title XIX coverage will be eligible for home and community-based services under the waiver. Applicants found eligible shall not be required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed November 17, 2008; effective February 11, 2009. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.04 Characteristics of Persons Requiring ICF/IID Care

(1) Generally, persons eligible for the level of care provided in an ICF/IID are those persons who need such level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three or more of the following areas of life activity:

- Self-Care
- Receptive and expressive language
- Learning
- Self-direction
- Capacity for independent living
- Mobility

(2) Services provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities in Alabama are those services that provide a setting appropriate for a functional individual with intellectual disabilities in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/IID care is made by a Qualified Intellectual Disabilities Professional (QIDP). A QIDP is an individual possessing, at minimum, those qualifications in 42 C.F.R. Section 442.401. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a QIDP and a physician.

(3) ICF/IID care includes those services that address the functional deficiencies of the beneficiaries and that require the skills of a QIDP to either provide directly or supervise others in the provision of services needed for the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment in which he or she can continue his/her individual developmental process.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.05 Qualifications of Staff Who Will Serve As Review Team for Medical Assistance

(1) The nurse shall be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person shall have knowledge and training in the area of mental retardation or related disabilities with a minimum of two (2) years' nursing experience.

(2) The social worker shall be a graduate of a four-year college with an emphasis in social work. This person shall have knowledge and training in the area of intellectual disabilities with a minimum of two (2) years' social work experience.

(3) The psychologist shall be a Ph.D. in Psychology. This person shall be a licensed psychologist with general knowledge of test instruments used for individuals with intellectual disabilities with a minimum of two (2) years' experience in psychology.

(4) Other professional disciplines which may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the clients are as follows:

(a) Special Education,
(b) Speech Pathologist,
(c) Audiologist,
(d) Physical Therapist,
(e) Optometrist,
(f) Occupational Therapist,
(g) Vocational Therapist,
(h) Recreational Specialist,
(i) Pharmacist,
(j) Doctor of Medicine,
(k) Psychiatrist, and

(l) Other skilled health professionals

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.06. Financial Accountability.
The financial accountability of providers for funds expended on home and community-based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients through the renewal period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the State of Alabama, the provider will pay all travel costs of the auditors to the location of the records.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.07 Individual Assessments
(1) Alabama Medicaid Agency will require an individual plan of care for each waiver service recipient. Such plan, entitled "Individual Habilitation Plan" (IHP), is subject to review by the Alabama Medicaid Agency and Department of Health and Human Services. The Alabama Medicaid Agency will review recipients' habilitation and care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures. Client assessment procedures in place in the Alabama Department of Mental Health, which are based on eligibility criteria for ICF/IIDs developed jointly by DMH and the Alabama Medicaid Agency, will be utilized by the Department of Mental Health (or its contract service providers) in screening for eligibility for the waiver services as an alternative to institutionalization. Whether performed by a qualified practitioner in the Department of Mental Health, its contract service providers, or provided by qualified (Diagnostic and Evaluation Team) personnel of the individual/agency arranging the service, review for "medical assistance" eligibility determination will be based on client assessment data, and the criteria for admission to an ICF/IID, as described in Rule No. 560-X-35-.03. Re-evaluation of clients shall be performed on an annual basis. Written documentation of all assessments will be maintained in the client's case file and subject to review by the Alabama Medicaid Agency and Department of Health and Human Services.

(2) The Alabama Medicaid Agency will give notice of services available under the waiver as required by federal regulations, particularly to primary care givers for the target group, including but not limited to, programs operated by Alabama Department of Mental Health, the statewide network of community MH centers, and to other appropriate care-giving agencies such as county Department of Human Resources offices, hospitals, hospital associations, and associations for individuals with intellectual disabilities.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.08 Informing Beneficiaries of Choice

(1) Alabama Medicaid Agency will be responsible for assurances that beneficiaries of the waiver service program will be advised of the feasible service alternatives and be given a choice of which type of service–institutional or home- and/or community-based services–they wish to receive.

(2) Residents of long-term care facilities for whom home and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of medical review. Applicants for SNF, ICF, ICF/IID services, or a designated responsible party with authority to act on the applicant's behalf, will be advised of feasible alternatives to institutionalization at the time of their entry into a treatment system wherein an alternative is professionally determined to be feasible. All applicants found eligible will be offered the alternative unless there is reasonable expectation that services required for the applicant would cost more than institutional care. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.09 Payment Methodology for Covered Services

(1) Actual reimbursement will be based on the rate in effect on the date of service.

(2) Rates will be established and reported to the Alabama Medicaid Agency's fiscal agent for claims submitted for payment.

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

(4) All claims for services must be submitted within one year from the date of service.

(5) Accounting for actual cost and units of services provided during a waiver year must be captured on the CMS 372 Report.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.10 Payment Acceptance.

(1) Payment made by the Medicaid Program to a provider shall be considered to be payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services for which Medicaid has been billed.

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.11 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 his/her guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.12 Records

(1) The Department of Mental Health 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. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent services shall be maintained by the clinic. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log complete with the date and nature of services provided must be signed by the recipient. If the recipient is unable to sign, the signature must be obtained by the responsible guardian/caregiver.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.13. Provider Enrollment

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider agreements 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.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 431, Subpart E–Fair Hearings for Applicants and Recipients.
History: New Rule: Filed September 20, 2002; effective December 2002.

Rule No. 560-X-52-.14 Cost for Services.

(1) The cost for services to individuals who qualify for home and community-based care under the waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap. Further, 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: Monica Abron, Administrator, LTC Program Management 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 September 20, 2002; effective December 26, 2002.
Amended: Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.15 HCBS Waiver Appeal Process.

(1) An individual receiving a Notice of Action (denial, termination, suspension, reduction in services) from the operating agency (OA), may request an appeal if he/she disagrees with the decision. The Notice of Action explains the reason for the denial, termination, suspension, or reduction in waiver services and the appeal rights made available to them.

(2) If an individual/guardian chooses to appeal an adverse decision, they may choose to appeal first to the Department of Mental Health, and if not satisfied with the decision rendered in that appeal, may then further appeal to the Alabama Medicaid Agency (AMA). Or, they may appeal first directly to the Alabama Medicaid Agency. The two processes are as follows:

(a) Appeal first to the Department of Mental Health (DMH) Associate Commissioner for the Division of Developmental Disabilities: a written request for an appeal must be received by the Associate Commissioner no later than 15 days calendar days after the effective date printed on the Notice of Action. Upon receipt of an appeal request by the Associate Commissioner, contact is made with the Regional Community Services Offices to request the information packet that they reviewed to base the denial decision. A written decision from the Associate Commissioner will be mailed (certified) to the individual/guardian within 21 days after the review of all information is completed. If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair Hearing from the AMA. A written hearing request must be received by the AMA no later than 15 calendar days from the date of the Associate Commissioner's response letter.

(b) Appeal first to the Alabama Medicaid Agency: a written request for an appeal must be submitted within 60 calendar days of the effective date printed on the Notice of Action. The AMA staff will assist the individual/guardian in scheduling a hearing.

(3) Services will continue until the final outcome of the hearing for those individuals who are already receiving services when they submit an appeal within 10 days after the effective date of action unless:

(a) It is determined at the hearing that the sole issue is of one of Federal or State law or policy; and

(b) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 431, Subpart E–Fair Hearings for Applicants and Recipients.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed June 11, 2014; effective July 16, 2014.

Rule No. 560-X-52-.16 Application Process

(1) The Alabama Medicaid Agency will provide the operating agency with the approved level of care determination process.

(2) The operating agency will review the applicant's eligibility status to determine if the applicant is medically eligible for waiver services. The target case manager will assist the recipient to make financial application and ensure that the appropriate documents are completed and routed to the appropriate Medicaid District Office if the individual is not already eligible and enrolled in an applicable Medicaid aid category. Financial eligibility must be certified by Medicaid.

(3) The Waiver Coordinator will complete the level of care determination and the case manager will develop the plan of care.

(4) The operating agency is required to adhere to all federal and state guidelines in the determination of the level of care approval.

(5) The operating agency or its designee (case manager), will ensure that the applicant has been screened and assessed to determine if the services provided through the LAH Waiver will meet the applicant's needs in the community.

(6) The Alabama Department of Mental Health (ADMH) 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 Living at Home Waiver.

(7) The Alabama Medicaid Agency will provide to the ADMH the approved Level of Care criteria and policies and procedures governing the level of care determination process.

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

(9) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Living at Home 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. The Waiver Quality Assurance Unit conducts a random sample of plans of care and related documents annually for each provider.

(10) 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.

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

(12) The operating agency or its designee will develop a plan of care that includes waiver as well as non-waiver services.

(13) Upon receipt of the financial award letter from the Alabama Medicaid Agency, the LTC Admissions Notification Form should be completed and forwarded to Medicaid's Fiscal Agent electronically. Medicaid's Fiscal Agent will either accept or reject the transmission of the LTC Admissions Notification Form. The operating agency or its designee will receive notice of the status of applications transmitted the next business day following the transmission.

(14) If Medicaid's Fiscal Agent accepts the transmission, the information is automatically written to the Level of Care file. The operating agency or its designee can begin rendering services and billing the Alabama Medicaid Agency for services rendered.

(15) If Medicaid's Fiscal Agent rejects the transmission, the operating agency or its designee must determine the reason for the rejection and retransmit the LTC Admissions Notification Form.

(16) Neither the Alabama Medicaid Agency nor Medicaid's Fiscal Agent will send out the LTC-2 Notification letters. The record of successful transmission will be the record of "approval" to begin rendering service.

(17) For applications where the level of care is questionable, providers may submit the applications to the Long Term Care Quality Assurance Unit for review by a nurse and/or a Medicaid physician.

(18) Once the individual's information has been added to the Level of Care File, changes can only be made by authorized Medicaid staff.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed March 20, 2007; effective June 15, 2007. **Amended:** Filed June 11, 2014; effective July 16, 2014.