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CHAPTER FIFTY-TWO

HOME AND COMMUNITY-BASED LIVING AT HOME (LH) WAIVER FOR PERSONS WITH INTELLECTUAL 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 (HCBS) under the Home and Community-Based Living at Home (LAH) Waiver 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 HCBS, require the level of care available in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). These HCBS under the LAH Waiver 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) The HCBS covered in the LAH Waiver are Residential Habilitation Other Living Arrangement Services, Day Habilitation Services, Prevocational Services, Supported Employment Services, Occupational Therapy Services, Speech and Language Therapy Services, Physical Therapy Services, Positive Behavior Support Services, Respite Care Services, Personal Care Services, Environmental Accessibility Adaptations Services, Specialized Medical Supplies Services, Specialized Medical Equipment Services, Skilled Nursing Services, Community Specialist Services, Crisis Intervention Services, Individual Directed Goods and Services, Assistance in Community Integration Services, Benefits and Career Counseling Services, Community Experience Services, Personal Emergency Response System (PERS) Services, and Supported Employment Emergency Transportation Services. These HCBS provide assistance necessary to ensure optimal functioning of individuals with intellectual disabilities.

(3) The LAH 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 LAH Waiver shall be given to individuals on a verified waiting list.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs.
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Rule No. 560-X-52-.02 Description of Services

Home and Community-Based Services (HCBS) under the Home and Community-Based Living at Home (LAH) Waiver for persons with Intellectual Disabilities are

defined as Title XIX Medicaid-funded services provided to individuals with intellectual disabilities who, without these services, would require services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). These HCBS under the LAH Waiver will provide health, social, and related support needed to ensure optimal functioning of individuals with intellectual disabilities 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 HCBS 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 HCBS under the LAH Waiver. The following are specific HCBS available under the LAH Waiver:

(1) In-Home Residential Habilitation Training Services

(a) In-Home Residential Habilitation Training Services provide care, supervision, and skills training in activities of daily living (ADL)s, home management and community integration.

(b) In-Home Residential Habilitation Training Service 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 (e.g. moving a chair, substituting Velcro closures for buttons or shoe laces, changing peoples' attitudes toward the waiver recipient, 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 waiver recipients 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 waiver recipient, will be included in payments made to providers of Residential Habilitation. Residential Habilitation service workers may transport waiver recipients in their own vehicles as an incidental component of In-Home Residential Habilitation Training Service.

(c) In-Home Residential Habilitation Training Services are provided to waiver recipients in their own homes, but not in group homes or other facilities.

(d) A unit of service is 15 minutes. The place of service will primarily be the waiver recipient's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

(e) In-Home Residential Habilitation Training Service 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 waiver recipient's plan may occur on the job. Waiver recipients 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 Training Service excludes the following:

1. Services, directly or indirectly, provided by a member of the waiver recipient'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 Services

(a) Day Habilitation Service 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) Transportation cost to transport waivers recipients 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 waiver recipients, will be included in the rate paid to providers for this service. Day Habilitation Service workers may transport waiver recipients in their own vehicles as an incidental component of this service. Providers of Day Habilitation Services must be certified by the Department of Mental Health.

(3) Prevocational Services

(a) Prevocational Services are aimed at preparing waiver recipients 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 waiver recipients 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, waiver recipients are paid at less than 50 percent of the minimum wage.

(c) Activities included in Prevocational Services 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 waiver recipient'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 Services

(a) There are three variations of Supported Employment Services: (1) Individual Assessment/Discovery (2) Small Group and (3) Individual.

1. Individual Assessment/Discovery is a one-time, time-limited target service designed to help a waiver recipient who wishes to pursue individualized, integrated employment or self-employment. Discovery may involve a comprehensive analysis of the waiver recipient's history; interviews with family, friends and support staff; observing the waiver recipient performing work skills; and career research in order to determine the waiver recipient's career interests, talents, skills, support needs and choice; and the writing of a Personal Profile Frames which will begin with the development of an employment plan.

2. Employment Small Group often consists of groups of waiver recipients being supported in enclave or mobile work crew activities. Employment Small Group are services and training activities provided in regular business, industry, and community settings for groups of two to eight workers with disabilities.

3. Employment Individual services are the ongoing support to waiver recipients obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which a waiver recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Employment Individual includes two distinct services: Job Developer and Job Coach.

(i) The Job Developer duties include, but are not limited to, marketing the Supported Employment Service and the waiver recipient's skills; negotiating hours or location to meet the abilities of the waiver recipient; and job placement.

(ii) The Job Coach enters once placement has been arranged. The Job Coach duties include, but are not limited to, assisting with training of waiver recipients in supported work to perform specific jobs consistent with their abilities; teaching waiver recipients associated work skills, responsibilities and behaviors not related to the specific job being performed; and providing continued ongoing support to waiver recipients in supported work.

(b) Supported Employment Services are 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 waiver recipients, 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 Services are not available to waiver recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

(e) 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

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

(g) Transportation will be provided between the waiver recipient's place of residence and the site of the habilitation services or between habilitation sites (in cases where the waiver recipient 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.

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

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

(5) Occupational Therapy Services

(a) Occupational Therapy Services are 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 a waiver recipient to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating waiver recipients 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 waiver recipient'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 waiver recipient and is necessary to enable the waiver 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 waiver recipient's approved plan of care and be provided and billed in 15 minute increments. Occupational therapy is covered under the State Plan for eligible waiver recipients as a result of an EPSDT screening. Therefore, this service is limited to waiver 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.

(6) Speech and Language Therapy Services

(a) Speech and Language Therapy Services 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 waiver recipients' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

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

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

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

(ii) Designing specialized programs for developing a waiver recipient's communication skills comprehension and expression.

(c) Therapists may also provide training to staff and caregivers (such as a waiver recipient'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 waiver recipient and is necessary to enable the waiver 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 as an encounter unit of service. Speech and Language Therapy Services are covered under the State Plan for eligible waiver recipients as a result of an EPSDT screening. Therefore, this service is limited to waiver 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.

(7) Physical Therapy Services

(a) Physical Therapy Services are physician-prescribed treatment of a waiver recipient 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 a waiver recipient 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 waiver recipient'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 waiver recipient and is necessary to enable the waiver 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 in 15 minute increments. Physical therapy is covered under the State Plan for eligible waiver recipients as a result of an EPSDT screening. Therefore, Physical Therapy Services are limited to waiver recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of Physical Therapy Services must maintain a service log that documents specific days on which Physical Therapy Services were delivered.

(8) Positive Behavior Support Services

(a) Positive Behavior Support Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for waiver recipients 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. Positive Behavior Support Services may include consultation provided to families, other caretakers, and habilitation services providers. Positive Behavior Support Services 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 Positive Behavior Support Service has three service provider levels: two professional levels and one technical level, each with its own procedure code and rate of payment. The Positive Behavior Support Service levels are distinguished by the supervision requirements and qualifications of the provider. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

1. Level 1 professional providers are required to have advanced degrees, specialization, and board certification in behavior analysis.

2. Level 2 professional providers are required to have advanced degrees and specialization with three years of experience working with waiver recipients. Professional providers at Level 2 who do not have a Doctorate degree require supervision by a Level 1 professional provider.

3. Level 3 technical providers are required to be either a QIDP or a Board Certified Assistant Behavior Analyst (BCABA). Level 3 technical providers require supervision by either a Level 1 professional provider or a Level 2 professional Doctoral provider.

(d) Positive Behavior Support Services tasks include the development of a BSP and implementation of the BSP in accordance with functional behavior analyses.

(e) Providers of Positive Behavior Support 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 Positive Behavior Support Service per year of both professional and technician level units combined cannot exceed 1200 and the maximum units of service of professional level cannot exceed 800.

(g) Positive Behavior Support Services can be directed by waiver recipients or family but must adhere to all the traditional service rules.

(9) Respite Care Services

(a) Respite Care Services are provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite Care Services provide 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 waiver recipients 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 Service. 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 waiver recipient in their home, or if necessary, to locate another home for them.

(c) Some waiver recipients 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 Service 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 Services shall be 1080 hours or 45 days per waiver recipient per waiver year.

(e) Out-of-home Respite Care Services may be provided in a certified group home or ICF/IID. In addition, if the waiver recipient is less than 21 years of age, out-of-home Respite Care Services may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a waiver recipient is receiving Out-of-Home Respite Care Services, 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 Services 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 waiver recipient in learning how to perform others; the planning team (composed at minimum of the waiver recipient and family, and a case manager or community specialist) shall determine the composition of the Personal Care Service and assure it does not duplicate, nor is duplicated by, any other service provided to the waiver recipient .

(c) A written description of what the personal care worker will provide to the waiver recipient is required to be submitted to the state as part of or in addition to the waiver recipient's approved 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 Services will not be approved for a waiver recipient 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 waiver recipient. 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 Personal Care Services are 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 waiver recipient's documented need for Personal Care Services 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 waiver recipient is eligible for the LAH 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 a 15 minute unit of service, not including worker's time of travel to and from the place of work.

(h) No payment will be paid for Personal Care Services furnished by a member of the immediate family (e.g., parents, spouses, children) living in the home or

who have a legal obligation to provide Personal Care Services. Siblings who do not reside in the home with the waiver recipient can be paid to provide Personal Care Services to the waiver recipient. 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 waiver recipient's record by the provider agency.

(i) Personal Care Services can also include supporting a waiver recipient at an integrated worksite where the waiver recipient is paid a competitive wage. Personal Care Services at an integrated worksite must be billed under a separate code to distinguish it from other Personal Care Services.

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

(k) Personal Care Transportation

1. Personal care attendants may transport waiver recipients 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 waiver recipient 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 waiver recipient as a result of being transported.

2. 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 waiver recipient.

3. Personal Care Transportation shall not replace transportation that is already reimbursable under Day or Residential Habilitation Services 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.

(11) Environmental Accessibility Adaptations Services

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

(b) Environmental Accessibility Adaptation Services may include adaptations which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver recipient and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems. Environmental Accessibility

Adaptation Services 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 recipient, such as carpeting, roof repair, central air conditioning, adding square footage to the home, etc. All Environmental Accessibility Adaptation Services shall be provided in accordance with applicable State or local building codes.

(c) The waiver recipient's home may be a house or an apartment that is owned, rented or leased. Environmental Accessibility 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 Environmental Accessibility Adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the waiver recipient and for which the property owner would not ordinarily be responsible.

(d) Environmental Accessibility Adaptations Services may be directed by waiver recipients or family but must adhere to all the traditional service rules.

(e) Total costs of Environmental Accessibility Adaptations Services shall not exceed $5,000 per waiver year, per waiver recipient.

(12) Specialized Medical Supplies Services

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

(c) Specialized Medical Supplies Services may be directed by waiver recipients or family but must adhere to all the traditional service rules.

(13) Specialized Medical Equipment Services

(a) Specialized Medical Equipment Services include devices, controls, or appliances, specified in the waiver recipient's approved plan of care, which enable waiver recipients to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized Medical Equipment Services include items that are 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. Specialized Medical Equipment 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 waiver recipient. Invoices for Specialized Medical Equipment must be maintained in the case record. Specialized Medical Equipment must be necessary to prevent institutionalization of the waiver

recipient. All items shall meet applicable standards of manufacturer, design, and installation. Costs are limited to 5,000 per waiver recipient, per year.

(b) Specialized Medical Equipment Services may be directed by waiver recipients or family but must adhere to all the traditional service rules.

(14) Skilled Nursing Services

(a) Skilled Nursing Services are services listed in the waiver recipient's approved 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 waiver recipient'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) Skilled Nursing Services may also be self-directed when provided to a waiver recipients or family which is self-directing Personal Care Services. Skilled Nursing Services includes training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker.

(15) Community Specialist Services

(a) Community Specialist Services are a time limited, task specific service that can include professional observation and assessment, individualized program design and implementation, training of waiver recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes as needed to facilitate and implement the Person Centered Plan. Community Specialist Services may also include, at the choice of the waiver recipient or family, advocating for the consumer and assisting him or her in locating and accessing both wavier and non-waiver services and supports. The Community Specialist will serve as both a qualified planner and, at the consumer's or family's request, a broker. The functions outlined for Community Specialist Services differs from case management in the skill level and independence of the specialist, as well as the focus on self-determination and advocacy for the individual.

(b) The provider must meet QIDP qualifications and be free of any conflict of interest with other providers serving the waiver recipient. The Community Specialist Services will assist the consumer and his caregivers to design and implement specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational skills, and behavior management. A community specialist with expertise in person centered planning may also be selected by the waiver recipient 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 Community Specialist Services 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 waiver recipient or family chooses to have the community specialist remain involved for a longer period of time, it must be agreed upon by the team and extended on the waiver recipient's approved plan of care. The need to extend the service must be fully justified in writing by the case manager. Community Specialist Services are limited to a 90-day period per waiver recipient per waiver year.

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

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

(h) Community Specialist Services are a cost effective and necessary alternative to placement in an ICF/IID. A unit of service is 15 minutes.

(16) Crisis Intervention Services

(a) Crisis Intervention Services provide immediate therapeutic intervention, available to a waiver recipient 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 waiver recipient or of others and/or to result in the waiver recipient's removal from his current living arrangement.

(b) Crisis Intervention Services may be provided in any setting in which the waiver recipient resides or participates in a program. Crisis Intervention Services include 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 Services will respond intensively to resolve crisis situations and prevent the dislocation of the waiver recipient 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. Crisis Intervention Services are 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 Crisis Intervention Services of a greater duration are required, the waiver recipient shall be transitioned to a more appropriate service program or setting.

(e) Crisis Intervention Services providers shall consist of a team under the direction and supervision of a QIDP. All team members shall have at least one year of work experience in serving individuals with intellectual disabilities and have a minimum of 40 hours training in crisis intervention techniques prior to providing Crisis Intervention Services.

(f) A unit of service is 15 minutes and must be provided by the waiver planning team, directed by a graduate psychologist or licensed social worker.

(g) When the need for Crisis Intervention Services arise, the service will be added to the waiver recipient's approved plan of care.

(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 ADMH prior to the service being initiated.

(j) Crisis Intervention Services will not count against the $25,000 per waiver recipient per year cap in the LAH Waiver, since the need for the Crisis Intervention 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 waiver recipient is physically aggressive or there is concern that the waiver recipient may take actions that threaten the health and safety of self and others;

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

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

(17) Individual Directed Goods and Services

(a) Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through the LAH Waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the waiver recipient'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 waiver recipient'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 waiver recipient 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 waiver recipient's saving account at the time of the request which is maintained by the Financial Management Services Agency, but not to exceed $10,000 annually.

(18) Assistance in Community Integration Services

(a) The Assistance in Community Integration Service enables waiver recipients to maintain their own housing as set forth in the waiver recipient's approved plan of care. Assistance in Community Integration Services must be provided in the

home or a community setting. Assistance in Community Integration Service includes the following components:

1. Conducting a community integration assessment identifying the waiver recipient's preferences related to housing and needs for support to maintain community integration.

2. Assisting waiver recipient with finding and securing housing as needed. This may include arranging for or providing transportation.

3. Assisting waiver recipient in securing supporting documents/records, completing/submitting applicants, securing deposits, and locating furnishings.

4. Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan. Identify and establish short and long-term measurable goal(s), and establish how goals will be achieved and how concerns will be addressed.

5. Participating in waiver recipients Person-Centered Plan meetings at re-determination and/or revision plan meetings as needed.

6. Providing supports and interventions per the waiver recipient's Person-Centered Plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of Community Integration services and address among the team.

7. Supports to assist the waiver recipient in communicating with the landlord and/or property manager regarding the waiver recipient's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.

8. Assistance in Community Integration Services will provide supports to preserve the most independent living arrangement and/or assist the waiver recipient in locating the most integrated option appropriate to the waiver recipient.

(19) Benefits and Career Counseling Services

(a) Benefits and Career Counseling Services comprise two distinct services: Benefits Reporting Assistance (BRA) and Benefits Counseling.

1. The BRA is designed to assist waiver recipients and their families to understand general information on how SSI/SSDI benefits are affected by employment. Once the waiver recipient enters employment, the BRA will be available to answer questions, assist in the execution of the work incentive plan, and assist with the submission of income statement and/or Impairment Related Work Expenses to SSA as required to the extent needed as indicated by the waiver recipient.

2. The Benefits Counseling is a more intensive service provided by a Community Work Incentives Coordinator (CWIC) who will provide intensive individualized benefits counseling, benefits analysis, develop a work incentive plan and ongoing benefits planning for a waiver recipient changing jobs or for career advancement. The CWIC will work in conjunction with the BRA to develop trainings and webinars based on SSA information provided and may assist or provide trainings and education as needed.

(b) The Benefits Counselor must be a Certified Work Incentives Counselor (CWIC) through a recognized training by the Social Security Administration for delivery

of Career Counseling Services. This may include a level 5 security clearance from the Social Security Administration/Department of Homeland Security due to Personally Identifiable Information.

(20) Community Experience Services

(a) Community Experience Services are non-work related activities that are customized to the waiver recipient(s) desires to access and experience community participation. Community Experience Services are provided outside of the waiver recipient's residence and can be provided during the day, evening, or weekends. The intent of Community Experience Services are to engage in activities that will allow the waiver recipient to either acquire new adaptive skills or support the waiver recipient in utilizing adaptive skills in order to become actively involved in their community.

(b) Community Experience Services has two distinct categories: Individual and Group Community Experience Services.

1. Community Experience Individual Services are provided to a waiver recipient, with a one-to-one staff to waiver recipient ratio which is determined necessary through functional and health risk assessments prior to approval. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval.

2. Community Experience Group Services are provided to groups of waiver recipients, with a staff to waiver recipient ratio of one to two or more, but no greater than four (4) waiver recipients.

(21) Personal Emergency Response System (PERS) Services

(a) Personal Emergency Response System Services (PERS) provides a direct telephonic or other electronic communications link between waiver recipients and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. PERS may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate.

(b) The use of PERS requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The waiver recipient's Person Centered Plan should identify options available to meet the need of the waiver recipient in terms of preference while also ensuring health, safety, and welfare.

(c) (PERS) can be directed by waiver recipients or family but must adhere to all the traditional service rules.

(22) Supported Employment Transportation Services

(a) Supported Employment Transportation Services permit waiver recipients transportation to and from their place of employment in the event that the support team is unable to facilitate transportation through other means. Supported Employment Transportation Services must be necessary to support the waiver recipient in work related travel and cannot be reimbursed for merely transportation.

(b) Transportation must be provided by public carriers (e.g., charter bus or metro transit bus) or private carriers (e.g., Taxicab). The waiver recipient may use a commercial transportation agency.

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 March 20, 2007; effective June 15, 2007. **Amended:** Filed November 17, 2008; effective February 11, 2009. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed July 12, 2017; effective August 28, 2017. **Amended:** Filed November 9, 2018; effective December 24, 2018.

Rule No. 560-X-52-.03 Eligibility

Medical eligibility for HCBS under the LAH Waiver is limited to those individuals that meet the ICF/IID level of care. No HCBS under the LAH Waiver 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, HCBS under the LAH Waiver will be available to persons with intellectual disabilities who would be eligible for institutional services under 42 C.F.R. §435.217.

Financial eligibility for HCBS under the LAH Waiver is limited to the following individuals:

- Individuals receiving SSI.
- SSI related protected groups deemed to be eligible for SSI/Medicaid (i.e., Widow/Widower, Disabled Adult Child, Continuous (Pickle) Medicaid).
- Parent and Other Caretaker Relatives (POCR).
- Federal and State adoption subsidy individuals.
- Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

Persons with intellectual disabilities who meet categorical (including 42 C.F.R. §435.120), medical, and/or social requirements for Title XIX coverage will be eligible for HCBS under the LAH 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. **Amended:** Filed July 12, 2017; effective August 28, 2017. **Amended:** Filed November 9, 2018; effective December 24, 2018.

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 intellectual 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. **Amended:** Filed July 12, 2017; effective August 28, 2017.

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.