

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The State of Alabama request to renew Alabama's Home and Community-Based Services Waiver for the Elderly and Disabled (E&D waiver). This renewal application includes the following changes and will have a positive impact on the E&D waiver program:

Companion Service- Removal of the 4 hour maximum service limit.

Respite Care- Removal of the 720 hour/year service limit.

Incorporate a person-centered process in order to align with the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services final rules.

Slot reservation- Waiver slots will be reserved for individuals who are currently being served and individuals who would have been served under the HIV/AIDS Waiver. This waiver will expire on 9/30/2017. The reallocation will allow the participants to receive more services than what is currently being offered under the HIV/AIDS Waiver.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Alabama Home and Community -Based Waiver for the Elderly and Disabled Waiver
- C. **Type of Request:** renewal

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: AL.0068

Draft ID: AL.023.07.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

10/01/17

1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

 Hospital

Select applicable level of care

 Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

 Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 Nursing Facility

Select applicable level of care

 Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

 Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

 Not applicable Applicable

Check the applicable authority or authorities:

 Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

 §1915(b)(1) (mandated enrollment to managed care) §1915(b)(2) (central broker)

- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.**
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Elderly and Disabled Waiver Program is to provide home and community-based services to elderly and disabled individuals in the community who would otherwise require nursing facility care. This waiver is aimed at providing quality and cost-effective services to individuals at risk of institutional care. The Alabama Medicaid Agency serves as the administering agency for this program and the Alabama Department of Senior Services serves as the Operating Agency.

Services provided under this waiver are case management, personal care, homemaker services, respite care (skilled and unskilled), companion services, adult day health, and home delivered meals.

This waiver includes a consumer directed care initiative called Personal Choices. Personal Choices is offered statewide through a concurrent 1915(j) authority. This state plan option gives individuals the opportunity to have greater involvement, control, and choice in identifying, accessing and managing their long term services and community supports. This Program allows self-direction for Personal Care, Homemaker, Unskilled Respite, and Companion services. All participants are given the opportunity to choose between the Personal Choices Program and traditional waiver services through the E&D waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a

combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the

assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

- I. Public Input.** Describe how the State secures public input into the development of the waiver:

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alabama**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

	<input type="text" value="Stone"/>
First Name:	<input type="text" value="Jean"/>
Title:	<input type="text" value="Division Chief"/>
Agency:	<input type="text" value="Alabama Department of Senior Services"/>
Address:	<input type="text" value="201 Monroe Street, RSA Tower Suite 350"/>
Address 2:	<input type="text" value="P.O. Box 301851"/>
City:	<input type="text" value="Montgomery"/>
State:	Alabama
Zip:	<input type="text" value="36130-1851"/>
Phone:	<input type="text" value="(334) 353-8288"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text"/>
E-mail:	<input type="text" value="Jean.Stone@adss.alabama.gov"/>

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	<input type="text" value="Ginger Wettingfeld"/> State Medicaid Director or Designee
Submission Date:	<input type="text" value="Sep 10, 2012"/>

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	<input type="text" value="Azar"/>
First Name:	<input type="text" value="Stephanie McGee"/>
Title:	<input type="text" value="Acting Commissioner"/>
Agency:	<input type="text" value="Alabama Medicaid Agency"/>
Address:	<input type="text" value="501 Dexter Avenue"/>
Address 2:	<input type="text" value="P.O. Box 5624"/>

City:	<input type="text" value="Montgomery"/>		
State:	Alabama		
Zip:	<input type="text" value="36103"/>		
Phone:	<input type="text" value="(334) 206-5600"/>	Ext:	<input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text" value="(334) 242-5097"/>		
E-mail:	<input type="text" value="Stephanie.Azar@medicaid.alabama.gov"/>		

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Prior to the submission of the initial STP in March 2015, Operating Agencies reviewed relevant regulations, policies and procedures, at least at a high level, to ensure consistency with the HCBS Final Rule promulgated by CMS. For the E&D waiver program, it was concluded at that time that regulations, policies and procedures appeared to be compliant with the

HCBS settings requirements. Following CMS feedback and the issuance of expanded guidance to states as to the expectation for the assessment process, additional assessment activities were conducted. ADSS and E&D staff have conducted a thorough examination of administrative code, policies, rules and regulations pertaining to the E&D waiver to evaluate whether they were sufficient to ensure compliance with the Final Rule. A crosswalk was developed to identify each applicable administrative code, policy, rule and/or regulation that addressed each of the Final Rule requirements:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
3. The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5. The setting facilitates individual choice regarding services and supports, and who provides them.
6. In a provider-owned or controlled residential setting, in addition to the qualities specified above, the additional conditions must be met. (Note: Not applicable to the E&D Waiver.)
7. HCBS settings exclude locations that have the qualities of an institutional setting. For 1915(c) home and community-based waivers, settings that are not home and community-based are defined at §441.301(c)(5) as follows:
 - a. A nursing facility;
 - b. An institution for mental diseases;
 - c. An intermediate care facility for individuals with intellectual disabilities;
 - d. A hospital; or
 - e. Any other locations that have qualities of an institutional setting, as determined by the Secretary.

Each of these documents was reviewed for consistency and compliance with each of the qualities defined at §441.301(c)(4) and §441.710 respectively, based on the needs of the individual as indicated in their person-centered plan. The completed crosswalk provides the appropriate citation for each administrative code, policy, rule and/or regulation and other applicable documents and indicates whether each was deemed compliant or non-compliant, including the basis for that determination. If no applicable citation could be identified that addressed a Final Rule requirement, the state's rules were considered to be silent in that area. For those Final Rule requirements for which the state's administrative code, policies, rules and/or regulations were not sufficiently compliant, or were silent, remedial strategies were devised and are included in the crosswalk with projected milestones and timelines. Note that the silence rating was also used for items that may have reflected some elements of a requirement, but were deemed to not fully address that requirement.

E&D Waiver Crosswalk is found in the Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Alabama Department of Senior Services (ADSS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by the Alabama Department of Senior Services (ADSS). AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. AMA also assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program and (3) Conducting quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs. The OA quarterly meeting is held to also discuss any issues and concerns as it relates to the overall operation of the program. This meeting helps the State to ensure that Federal and State guidelines are being followed in accordance with the approved waiver document.

AMA Quality Assurance has developed a Quality Management Strategy for the E&D Waiver Program. The

following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfaction surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved. AMA Quality Assurance also mails satisfaction surveys to clients on a quarterly basis, and tracks any complaints and/or grievances that are received.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

Based on the provisions within the 1915(j)State Plan Program, Personal Choices waiver participants will be given the opportunity to self-direct personal care services. This option is administered through ADSS.

The operating agency will use a FMSA contractor that has the capabilities to perform the required tasks in accordance with Section 3504 of the IRS CODE and Revenue Procedure 70-6. The FMSA will assist waiver participants who have chosen to self-direct services with hiring and paying their staff, completing background checks on potential Personal Choices employees, address all applicable payroll taxes of Personal Choices employees, processing time sheets, and paying the employees. The FMSA is paid a flat rate per month per participant.

The monthly rate of an initial enrollee is slightly higher for the first month to accommodate the cost of the background screening and enrollment.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

The Operating Agency/ADSS will contract with Alabama's 13 Area Agencies on Aging (AAA to execute case management. ADSS will monitor these functions as outlined in the MOU and/or policies and procedures.

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which

private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Operating Agency will assess the performance of the contracted entity.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Operating Agency will perform annual audits on contracted and local/regional non state entities.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of data reports specified in the agreement with the Medicaid Agency that were submitted on time and in the correct format.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Alabama Medicaid Agency (AMA) exercises administrative authority and responsibility of all waiver related policies and the OA's adherence to rules and regulations governing the E&D Waiver. AMA conducts meetings to disseminate policies, rules and regulations in an effort to ensure consistent application of the policies related to the E&D Waiver program.

AMA reviews participant files, personnel files and performs home visits as a method to monitor compliance of the level of care determination process;the appropriateness of the Person Centered Care Plan (PCCP); and the monitoring of service providers contracted with ADSS.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

AMA monitors the Quality Improvement Strategy (QIS)of the waiver on an ongoing basis. If a problem is identified, AMA sends a notice to ADSS addressing the issue(s) and require a response as to their follow-up plan of correction and/or corrective measures to resolve any/all problems identified.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	<input type="text" value="65"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	<input type="text" value="0"/>	<input type="text" value="0"/>	
	<input checked="" type="checkbox"/>	Disabled (Other)	<input type="text" value="0"/>	<input type="text" value="0"/>	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The E&D Waiver requires all clients to meet the nursing facility level of care.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a,

specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	9355
Year 2	9355
Year 3	9355
Year 4	9355
Year 5	9355

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes
HIV/AIDS Waiver Transition
Nursing Facility Transition Assistance

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

HIV/AIDS Waiver Transition

Purpose (*describe*):

These slots are reserved for individuals who HCB services would have been provided under the HIV/AIDS Waiver.

Describe how the amount of reserved capacity was determined:

The reserve capacity was determined by reassigning the 150 approved slots currently allocated under the HIV/AIDS Waiver to the E&D Waiver. We will transfer about 50 clients to the E&D Waiver. Our estimation is that no more than 20 reserved slots/year will be needed to enroll new individuals who would have been served under the HIV/AIDS Waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	70
Year 2	20
Year 3	20

Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Nursing Facility Transition Assistance

Purpose (describe):

The purpose of reserving the slots is to assist Alabama Medicaid eligible recipients who desire to transition from nursing facilities back into the community. The reservation of these slots will allow those individuals who are able to transition to be placed in a preserved waiver slot during the current waiver year.

Describe how the amount of reserved capacity was determined:

The Operating Agency has estimated that 25 slots/year would be the amount needed to place in reserve for the individuals transitioning from the nursing facility to the waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is based on the date of application and the need for services that is determined through an assessment process completed by the Case Manager, Nurse reviewer, and the applicant's physician. The PCCP is developed based upon feedback from the participant/representative and the attending physician. It is based upon the individual needs of the participant and the available formal and informal supports.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals eligible under 42 CFR 435.145 and 435.227.

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the State plan**

Select one:

- SSI standard**
 Optional State supplement standard
 Medically needy income standard
 The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
 A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.

- Other**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable (see instructions)
 SSI standard
 Optional State supplement standard
 Medically needy income standard
 The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

The state uses post-eligibility rules for the period between January 1, 2014 and December 31, 2018 as per section 2404 of the ACA.

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
 AFDC need standard
 Medically needy income standard
 The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the State plan**

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which included income placed in a Miller Trust.

- Other

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

The state is using post-eligibility rules for the period January 1, 2014 through December 31, 2018 as per

part of 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

The state is using post-eligibility rules for the period January 1, 2014 through December 31, 2018 as per part of 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:**

Specify formula:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income placed in a Miller Trust.

Other

Specify:

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
 The State does not establish reasonable limits.
 The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

- i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be

determined to need waiver services is:

ii. **Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

All clients are monitored through at least one monthly face-to-face visit by the case manager. The monthly face-to-face visit is the minimum monthly contact. Monitoring of participants is conducted more frequently if there is a change in the participant's medical condition or if there is a change in the participant's environmental circumstances. The frequency of other waiver services is determined by the physician based upon the needs of the waiver participant and is specified on the participant Person Centered Care Plan.

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

- Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The OA/ADSS have Nurse Consultants on staff that perform the initial evaluations. They are Registered Nurses with a State of Alabama license.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The E&D Waiver recipients must meet the nursing facility level of care. The tool used to determine the NF LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form. New admissions and re-determinations must meet two of the criteria listed in A-K. Supporting documentation must be submitted with the application.

The admission criteria is as follows:

A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment. (Cannot be counted as a second criterion if used in conjunction with criterion K-7)

B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.

- C. Nasopharyngeal aspiration required for the maintenance of a clear airway
- D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created. (Cannot be counted as a second criterion if used in conjunction with criterion K-3 if the ONLY stoma (opening) is a G or PEG tube.)
- E. Administration of tube feedings by naso-gastric tube.
- F. Care of extensive decubitus ulcers or other widespread skin disorders.
- G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse. (Cannot be counted as a second criterion if used in conjunction with criterion K-9)
- H. Use of oxygen on a regular or continuing basis.
- I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders.
- J. Comatose client receiving routine medical treatment.
- K. Assistance with at least one of the activities of daily living below on an ongoing basis:
 - 1. Transfer- The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or two or more times per week).
 - 2. Mobility- The individual requires physical assistance from another person for mobility on an ongoing basis (daily or two or more times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane or other mobility aid shall not by itself be considered to meet this requirement.
 - 3. Eating – The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement. (Cannot be counted as a second criterion if used in conjunction with criterion D if the ONLY stoma (opening) is a G or PEG tube.)
 - 4. Toileting – The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care on an ongoing basis (daily or two or more times per week).
 - 5. Expressive and Receptive Communication – The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language: or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform of complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
 - 6. Orientation – The individual is disoriented to person (e.g., fails to remember own name or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).
 - 7. Medication Administration – The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes but not limited to, reminding when to take medications, encouragement to take reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (Cannot be counted as a second criterion if used in conjunction with criterion A)
 - 8. Behavior – The individual requires persistent staff intervention due to an established and persistent pattern of dementia- related behavioral problems (e.g., aggressive physical behavior, disrobing or repetitive elopement attempts).
 - 9. Skilled Nursing or Rehabilitative Services – the individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than for practical purposes would be provided through a daily home health

visit. Cannot be counted as a second criterion if used in conjunction with criterion G)

Criterion K should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided an individual Level of Care (LOC) evaluation. The case managers submit a Home and Community Based Waiver (HCBS-1) application to the nurse reviewer on staff at the Operating Agency to evaluate and make the level of care determination. The nurse reviewers evaluate the application to make sure it is complete, supports the need for waivers services, establishes the risk of nursing home placement and the medical criteria is met and level of care is approved. The approval of the appropriateness of admission or continued eligibility is assessed from the documentation as per the HCBS-1 assessment tool and other documents which may include physician progress notes, and/or hospital records. A review not only includes meeting the level of care criteria as developed by the Alabama Medicaid Agency but also the assessment of the support systems within the home, the functional limitations of the recipient, the diagnosis and any factors that would place the recipient at risk of institutionalization. Medicaid may also assist with difficult LOC evaluations.

Once the application is approved it's entered electronically into the Fiscal Agent system. If no problems are identified, the Fiscal Agent enters the approval in the AMA Long Term Care file and writes a waiver eligibility segment indicating the beginning and ending eligibility dates. Verification and acceptance will be returned overnight to ADSS.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months**
 - Every six months**
 - Every twelve months**
 - Other schedule**

Specify the other schedule:

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

Specify the qualifications:

--

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Reevaluations of eligibility for the E&D Waiver must be completed every twelve months. This process is the same as the initial application packet which includes a new level of care, and PCCP. Reevaluations must be done on a timely basis so that services and payment will not be interrupted. Billing for Waiver services is bounced against the Waiver Service Long Term Care Benefit Plan, and if eligibility for Waiver Services is current, the claim is paid. The Alabama Medicaid Agency will not back date reevaluations not received in a timely manner.

All recipients enrolled in the Elderly & Disabled waiver must have an annual re-determination of need for the nursing facility level of care to continue to qualify for services through these waivers. The first re-determination of need for the level of care is to be made within a year of the individual's initial determination.

PROCEDURE:

1. The Case Manager must complete the re-determination application, the HCBS Medical Form, Form 204/205, and obtain medical documentation to support the re-determination. This documentation should include hospital notes, lab, x-rays, etc., to support the diagnosis and should also include the most recent 6 months to 1 year of physician office notes. The Case Manager will route this packet of information to the Operating Agency Nurse Reviewer.

The Operating Agency Nurse Reviewer will determine Level of Care (LOC). If LOC is met, the Operating Agency Nurse Reviewer will complete and attach the Waiver Medical Form/Waiver Slot Confirmation Form (Form 376) to the packet will be submitted to the Alabama Medicaid Agency for processing.

The Medicaid District Office will issue a financial award notice or denial notice. A copy of the notice will be faxed by the Medicaid District Office to the appropriate Operating Agency. Once the Operating Agency receives the financial award notice the application will be processed into the LTC Admission Notification software.

The operating agency may submit an early re-determination application as early as 90 days before the annual re-determination date. Applications received prior to 90 days of the annual date will be returned. All re-determinations must be completed before the LOC segment date expires.

The Operating Agency will print a list of participants who has a redetermination date within 90 days. If an application is not process within 15 days of the re-determination date, the OA will research and solve the problem before the determination expires.

If the re-determination does not process due to an error beyond the control of the OA or AMA (IT glitches, appeal process, etc), the waiver participant will not be disenrolled from the program. Waiver services will continue and be paid upon the receipt of the claim. The OA will request AMA to manually make these changes as directed by the policy and procedures.

Case Managers also keep a copy of the client's reevaluation dates in a tickler file to ensure timely re-evaluations are accomplished.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and reevaluations are maintained for a minimum period of 3 years. The clients records are located at the Operating Agency/ ADSS and the Case Management Agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of applicants who receive a Level of Care assessment conducted by the case management agency prior to receiving waiver services. N: Number of persons who receive a LOC assessment prior to receiving services. D: Total number of applicants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their last. N: Number of participants who received a redetermination within 12 months of their last assessment. D: Total number of participants who received a redetermination assessment.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each)</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<i>that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of LOC determinations applied appropriately and correctly using the LOC criteria and instrument as described in the approved waiver. N: Number of LOC determinations applied using the approved LOC criteria and instrument. D: Total Number of LOC evaluations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Alabama Medicaid Agency (AMA) has granted the OA Nurse Consultant the authority to make the level of care (LOC) determinations and annual redeterminations (reevaluations). The AMA Nurse Reviewer will randomly select a percentage of applications for a monthly retrospective review. The AMA Nurse Reviewer will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes, and/or any other documentation to support the participant's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (reevaluation) must be completed every twelve months.

The process is the same as for an initial evaluation.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by ADSS. AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, (3) Conducts quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs.

The AMA Waiver Quality Assurance has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance

issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.

Egregious non-compliant issues are addressed differently and on a case-by-case basis. The State will contact the Operating Agency upon receipt of notification and establish a 24-hour action plan.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice: being informed of feasible alternatives under the waiver.

As part of the assessment and service coordination visit, clients and/or responsible parties are provided with adequate

information to make an informed decision as to where the client's care will be received. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the client, both formal and informal, as well as those waiver services which may be available to meet the client's needs and those needs which cannot be met.

Freedom of Choice: Case Managers inform applicants of all direct service providers and allowed his or her freedom of choice of providers; and the choice of either institutional or home and community based services.

Each waiver client must make a written choice for either institution or community care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained in the Operating Agency Case Record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanic is the only significant Limited English proficiency population in the State of Alabama at 1.7%.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Skilled Respite		
Other Service	Companion Service		
Other Service	Home Delivered Meals		
Other Service	Unskilled Respite		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is not an entitlement. It is based on the needs of the individual client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the PCCP and the Service Authorization Form.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Day Care Worker
Individual	Registered Nurse or Licensed Practical Nurse
Individual	Director of Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Individual ▾

Provider Type:

Adult Day Care Worker

Provider Qualifications

License (specify):

Alabama Driver's License

Certificate (specify):

None

Other Standard (specify):

Have a valid Alabama driver's license if transporting Adult Day Health clients; possess a valid, picture identification; all Adult Day Health Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified as Necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Individual ▾

Provider Type:

Registered Nurse or Licensed Practical Nurse

Provider Qualifications

License (specify):

Licensed by the Alabama Board of Nursing

Certificate (specify):

None

Other Standard (specify):

Preferably with at least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified as initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Individual

Provider Type:

Director of Center

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

Have a high school diploma or equivalent; test for tuberculosis annually

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified as Necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Empty text input field with a scroll arrow on the right side.

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Empty dropdown menu for Category 1.

Category 2:

Sub-Category 2:

Empty dropdown menu for Category 2.

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services.

Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Person Centered Care Plan. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver clients

Case Management activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen minutes (15) beginning on the date that the client is determined eligible for E/D Waiver Services. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.

There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor. For Transitional CM a unit of service that assists individuals transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. If Transitional CM is provided it should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the E&D Waiver, reimbursement will be at the administrative rate.

In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the PCCP development and signing the service authorization log if the recipient is unable to do so. The Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the PCCP.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**

- Relative**
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Individual	Bachelor of Arts or Bachelor of Science Degree

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual ▾

Provider Type:

Registered Nurse

Provider Qualifications**License (specify):**

State of Alabama

Certificate (specify):

Other Standard (specify):

License must be current

Verification of Provider Qualifications**Entity Responsible for Verification:**

ADSS

Frequency of Verification:

Verified initially and annually.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual ▾

Provider Type:

Bachelor of Arts or Bachelor of Science Degree

Provider Qualifications**License (specify):**

None

Certificate (specify):

None

Other Standard (specify):

Preferably in a human services related field from an accredited college or university

Verification of Provider Qualifications**Entity Responsible for Verification:**

ADSS

Frequency of Verification:

Verified initially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Homemaker ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the PCCP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the PCCP. The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker
Individual	Homemaker Supervisor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual ▾

Provider Type:

Homemaker

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

None

Other Standard (*specify*):

Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The workers must get a tuberculin skin test annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual ▾

Provider Type:

Homemaker Supervisor

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

None

Other Standard (*specify*):

Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The workers must get a tuberculin skin test annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Personal Care ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

Personal Care services provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It

may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family. Personal Care Services is not an entitlement. It is based on the needs of individual client as reflected in the PCCP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct PC Service provided in the client's residence. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the client's plan of care. The amount of time authorized does not include the Personal Care Worker's transportation time to or from the client's residence, or the worker break or mealtime.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse or Licensed Practical Nurse (in supervisory capacity)
Individual	Personal Care Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual ▾

Provider Type:

Registered Nurse or Licensed Practical Nurse (in supervisory capacity)

Provider Qualifications

License (*specify*):

Current license from the State of Alabama.

Certificate (*specify*):

None

Other Standard (*specify*):

Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual ▾

Provider Type:

Personal Care Worker

Provider Qualifications**License (specify):**

None

Certificate (specify):

None

Other Standard (specify):

Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency. The Personal Care Worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training per calendar year is also required.

Verification of Provider Qualifications**Entity Responsible for Verification:**

ADSS

Frequency of Verification:

Verified initially and bi-annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▾

Service:

Respite ▾

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:**Category 1:** ▾**Sub-Category 1:****Category 2:** ▾**Sub-Category 2:****Category 3:** ▾**Sub-Category 3:****Category 4:** ▾**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's PCCP established by the Case Manager.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Practical Nurse- LPN (skilled respite)
Individual	Registered Nurse -RN (Skilled Respite)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Skilled Respite

Provider Category:

Individual ▼

Provider Type:

Licensed Practical Nurse- LPN (skilled respite)

Provider Qualifications

License (specify):

State of Alabama

Certificate (specify):

None

Other Standard (specify):

This service will be performed by a Licensed Practical Nurse with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a LPN in

public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. The LPN must work under the supervision of an RN.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Skilled Respite

Provider Category:

Individual ▾

Provider Type:

Registered Nurse -RN (Skilled Respite)

Provider Qualifications

License (specify):

Licensed by the Alabama Board of Nursing

Certificate (specify):

None

Other Standard (specify):

This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Service

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▾

Category 2:**Sub-Category 2:**

	▼
--	---

Category 3:**Sub-Category 3:**

	▼
--	---

Category 4:**Sub-Category 4:**

	▼
--	---

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

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

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the PCCP and the Service Authorization Form. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the client.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Companion Worker

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Companion Service

Provider Category:

Individual ▾

Provider Type:

Companion Worker

Provider Qualifications**License (specify):**

None

Certificate (specify):

None

Other Standard (specify):

Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program. All Companion Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications**Entity Responsible for Verification:**

ADSS

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:**Category 1:**
 ▾
Sub-Category 1:**Category 2:**
 ▾
Sub-Category 2:**Category 3:**
 ▾
Sub-Category 3:**Category 4:**
 ▾
Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Home Delivered Meals are provided to an eligible waiver participant who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the participant can be addressed by the provision of home-delivered meals.

When specified in the Person Centered Care Plan, this service may include seven (7) or fourteen (14) frozen meals per week. In addition, the service may include the provision of two (2) or more shelf-stable meals to meet emergency nutritional needs when authorized on the participant's Plan of Care.

During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the Meals Coordinator will coordinate with the vendor to implement a Disaster Meal Services Plan .

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual, and the unit(s) of service needed will be specified in the PCCP. The unit of service is one (1) package of seven meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the participant’s residence.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Driver of delivery truck
Individual	Registered Dietician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Individual ▼

Provider Type:

Driver of delivery truck

Provider Qualifications

License (specify):

Valid driver's license

Certificate (specify):

Other Standard (specify):

Should receive initial and on-going training in the proper service, handling, and delivery of food.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and monitored on an on-going basis.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Individual ▾

Provider Type:

Registered Dietician

Provider Qualifications

License (specify):

State of Alabama valid state license

Certificate (specify):

None

Other Standard (specify):

Current dietician registration

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Unskilled Respite

HCBS Taxonomy:

Category 1:

▾

Sub-Category 1:

Category 2:

▾

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the PCCP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's PCCP established by the Case Manager.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Respite Care Worker- Unskilled

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Unskilled Respite

Provider Category:

Provider Type:

Respite Care Worker- Unskilled

Provider Qualifications

License (specify):

None

Certificate (*specify*):

None

Other Standard (*specify*):

This service will be performed by non licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision.

Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker and submit to a program for testing, prevention and control of tuberculosis.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADSS

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Background checks will be required for direct service provider employees who operate within the State of

Alabama and who either provide direct services to the participant and/or who have access to client records. The state background checks will be conducted by the provider agency and will also include a reference check with previous employers, sex offender registry, and the Nurse/Aid Registry. Verification of investigations will be conducted during audit reviews of the service providers by the OA.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Only as described in Appendix E related to the 1915j

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A) Services provided by relatives or friends may be covered only if relatives or friends meet the same qualifications as other direct care providers and are employed by an approved provider of service. Relatives who are providers of services cannot be a parent/guardian of a minor or spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be justification as to why the relative or friend is the provider of care and documentation in the case manager's file showing the lack of other qualified providers.

(B) The strict controls to assure that payment is made to relatives or friends as providers in return for authorized services include the following:

- 1) The relative or friend must be employed by a Direct Service Provider (DSP) Agency.
- 2) Meet the qualifications outlined in the scope of service as any other personal care, respite, homemaker, or companion worker employed by a DSP agency.
- 3) Complete a service log reflecting the type of service provided including the number of hours of service, the date and time of service.
- 4) Have the client/or representative sign the service log at each visit. If the relative or friend normally acts as a representative another individual must sign the service log.
- 5) The service log is reviewed by a DSP supervisor at least once biweekly.
- 6) Supervisory visits to the participant's residence at 60 day intervals.
- 7) Direct on-site supervision of the DSP worker providing the authorized service at least once every 6 months and more frequently if warranted.
- 8) Monthly visits by the case managers to address client satisfaction with the provision of services and to question the client confidentially about the adequacy of the services received and their needs are met as well as to observe the client or friend as services are provided.

(C) While each service may be offered by a relative the state will ensure that no conflict of interest will occur because the relative providing the direct service will not be involved in the development of the PCCP or allowed to sign service logs which serve as documentation that the authorized services have been provided when the participant is unable to do so. When the primary care giver or authorized representative for the participant must also act as the direct service provider worker another individual must be assigned the aforementioned responsibilities as well as assume responsibility for any other functions which could potentially result in a conflict of interest. The case manager must be available during the monthly visits to observe the provision of the direct service by the guardian and question the participant confidentially about their satisfaction with those services.

D. Personal Choices participants may hire legally liable relatives as paid providers of services. However, restrictions do apply on participant living arrangements, when homes or property are owed, operated or

controlled by a provider of services, not related by blood or marriage to the participant.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared; and mailed that outlines all the certification requirements to become a waiver provider. After the package is returned it is reviewed for completeness of information. The OA will conduct an initial on-site visit to verify that the provider is in compliance with Medicaid Waiver standards and regulations before approval as a direct service provider is made. Every new provider is also required to attend a waiver training conducted by the OA.

When all information from the potential provider has been reviewed and verified, a payment rate is established and a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement of the Elderly and Disabled Waiver based on the OA's review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter. All willing and qualified providers are given an opportunity to enroll as an waiver provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new provider applications, by type, for which the provider obtained appropriate licensure/certification in accordance with waiver provider qualifications prior to service provision. N: Number of provider applications, by

provider type, who met certification and qualifications prior to service provision.
D: Total number provider applications

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number and percent of providers, by provider type, continuing to meet applicable licensures/certification following initial enrollment. N: Number of providers, by type, continuing to meet certification. D: Total number of current providers.

Data Source (Select one):
On-site observations, interviews, monitoring
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):
Record reviews, off-site
 If 'Other' is selected, specify:
Via Medicaid's fiscal agent

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. N: Number of enrolled non-licensed/non-certified providers, by type, who continue to meet provider qualifications. D: Total number of non-licensed/non-certified providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of enrolled providers, by provider type, meeting provider training requirements. N: Number of enrolled providers, by provider type, meeting training requirements. D: Total number of enrolled providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
<input checked="" type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <input type="text"/>	

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The OA must investigate all high risk health and safety issues upon receipt of notification and initiate action within 24 hours. If necessary the recipient and/or DSP will be interviewed. The OA must also notify AMA within two working days. ADSS and AMA will review the issue to determine if there is a pattern of problems and no health and safety risks exist. AMA will contact the client via telephone to ensure full resolution to the incident has been completed satisfactorily. Any final determinations including any DSP probations and or termination will be reported to the AMA.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <input type="text"/>	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

II. Systemic Findings and Remediation

The findings of the systemic assessment and proposed remediation strategies for the E&D waiver are summarized in the table below. There are three applicable crosswalks, one applying to services provided in individuals' private homes and integrated employment, one related to services provided in foster homes and another specifically to Adult Day Health Services. The complete E&D Waiver crosswalks may be found in Appendix A of the Statewide Plan. It includes detailed descriptions of each finding, the basis for each determination of compliance, and any needed remedial strategies with milestones and projected completion date.

Requirement #1

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

Summary

This requirement of the Final Rule was not fully addressed for the E&D Waiver. The following will require revision to reflect requirements that settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS:

- E&D Waiver
- AMA Administrative Code, Chapter 36
- Alabama Medicaid Adult Day Health Standards
- Scope of Service for Adult Day Health Service
- Alabama Medicaid Adult Day Health Review Tool
- Long Term Care Waiver Quality Assurance Manual
- Medicaid Waiver Survey for Participants
- AMA E&D Waiver Policy Manual
- ADSS Medicaid Waivers Case Management Guide, Assessment Forms, Home Visit Tool

Requirement #2

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and

board.

Summary

Individuals are served in private homes of their choice with the exception of Adult Day Health services, which are the only services offered in a provider-controlled setting. Each client is given choice of either institutional or the home and community based services as well as given information necessary to make informed choices regarding the location of care, but key documents related to Adult Day Health are silent as to whether individuals are offered non-disability specific settings and will need revision. These include the following:

- Alabama Medicaid Adult Day Health Standards
- Alabama Medicaid Agency Administrative Code, Chapter 36
- Scope of Service for Adult Day Health Service
- Alabama Medicaid Adult Day Health Review Tool

Requirement #3

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Summary

The E&D Waiver was largely compliant with this requirement as it relates to privacy, dignity and respect, which were addressed in a comprehensive manner with one exception. The AMA E&D Waiver Policy Manual does not reference dignity and respect and will need revision. As to freedom from coercion and restraint, the E&D Waiver provides that the State does not permit the use of restrictive interventions, restraints and seclusion and assures monitoring on a monthly basis by case managers as well as oversight by the appropriate state agencies. The ADSS Medicaid Waivers Case Management Guide and Home Visit Tool will require revision to fully address this element as it relates to case manager responsibility for assessment, monitoring and documentation to ensure compliance with safeguards against restraint, restrictive interventions and seclusion. The Medicaid Waiver Survey for Participants Includes questions/probes regarding being treated with dignity and respect, but revisions should be considered to add probes regarding freedom from coercion and restraint.

Requirement #4

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Summary

AMA Administrative Code, Chapter 36 is only partially compliant with this requirement. Adult Day Health and Companion services provide some language related to this requirement, such as education and training for health and self-care and promoting client independence, but this section of the Code does not fully address the optimization of individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. The AMA E&D Policy Manual is also silent regarding this requirement and will be revised. The ADSS Medicaid Waivers Case Management Guide, Assessment Forms and Home Visit Tool also do not fully address this element as it relates to case manager responsibility for assessment, monitoring and documentation to ensure compliance and will require revision.

Requirement #5

Facilitates individual choice regarding services and supports, and who provides them.

Summary

The E&D Waiver was largely compliant with this requirement, addressing the right of individuals regarding services and supports, and who provides them, including how this choice will be facilitated in the intake and planning processes as well as on an ongoing basis. The AMA January 2016 Provider Manual will require revision to add clarifying language that all individuals will be advised of available services and given choice of providers.

Requirement #6

In a provider-owned or controlled residential setting, in addition to the qualities specified above, additional conditions must be met.

Summary

Not applicable to the E&D Waiver. No waiver services are provided in provider owned or controlled residential settings.

Requirement #7

HCBS settings exclude locations that have the qualities of an institutional setting.

Summary

None of the documents pertaining to the E&D Waiver fully address this requirement as it relates to settings that have the qualities of an institution or are presumed to have qualities of an institution. They do not fully address exclusion of all institutional or presumed-institutional setting nor do they describe a process for identification and scrutiny of such settings.

Revisions will be required to the following documents:

- E&D Waiver
- AMA Provider Manual, Explanation of Covered Services
- AMA Administrative Code, Chapter 36
- Alabama Medicaid Adult Day Health Standards
- Scope of Service for Adult Day Health Service
- Alabama Medicaid Adult Day Health Review Tool
- Long Term Care Waiver Quality Assurance Manual
- Medicaid Waiver Survey for E&D Participants
- ADSS Medicaid Waivers Case Management Guide, August 2014; Assessment Forms and Home Visit Tool

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Care Plan (PCCP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case Management will be conducted by Case Managers who meet the minimum qualifications below:

A. Professionals having earned a Bachelor of Arts degree or a Bachelor of Science degree, preferably in social work, psychology or related field from an accredited college or university, or a degree from an accredited School of Nursing.

B. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by AMA and attend on-going training and in-service programs deemed appropriate. Initial orientation and training must be completed within the first three months of case manager employment. Proof of the training must be recorded in the Case Manager's personnel file. Case Management training must be completed prior to case managers being authorized to provide services. Any exception to this requirement must be approved by AMA.

C. The Operating Agency will be responsible for providing a minimum of six hours relevant in-service training per calendar year for Case Managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year. Documentation of the training shall include: topic, name and title of trainer, training objectives, and outline content, length of training, list of trainees, location and training outcomes. Topics for specific in-service training may be mandated by AMA.

Annual in-service training is in addition to the required orientation and training. Proof of training must be recorded in the personnel file. The operating agency shall submit proposed programs to Medicaid at least 45 days prior to the planned implementation. Any exception must be approved by AMA.

D. The OA must have a Quality Assurance Program for case management services in place and approved by AMA. The Quality Assurance program shall include case manager record reviews at a minimum of every 90 days. Documentation of quality assurance reviews and corrective action plans must be maintained by the OA and will be subject to review by AMA.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

The DSP must provide all of the following and may make sub-contractual arrangements for some, but not all of the following:

1. The registered nurse(s) must meet the following requirements:
 - a. Currently licensed by the Alabama State Board of Nursing to practice nursing.
 - b. Must pass a statewide and local background check.
 - c. Preferably at least two years experience as a registered nurse
 - d. Make the initial visit to the participant's residence prior to the start of services for the purpose of reviewing the PCCP and giving the participant written information regarding advance directives.
 - e. Current verification of an annual TB Skin Test and CPR certification must be in the employee's personnel record.

The DSP may employ or may make sub-contractual arrangements for a Licensed Practical Nurse who must meet the following requirements:

2. A licensed practical nurse(s) must work under the supervision of the registered nurse and must meet the following requirements:
 - a. Currently licensed by the Alabama State Board of Nursing to practice nursing.
 - b. Preferably at least two years experience as a licensed practical nurse
 - c. Must pass a local and statewide background check.
 - d. Capable of evaluating the worker in terms of his or her ability to carry out assigned duties and his/her ability to relate to the client.
 - e. Ability to assume responsibility for in-service training for workers by individual instruction, group meetings or workshops.
 - f. Current verification of an annual TB Skin Test and CPR certification must be in the employee's personnel record.
3. Personal Care Workers who meet the following qualifications and requirements:
 - a. Must have references which will be verified thoroughly.
 - b. Must pass a local and statewide background check.
 - c. Must be able to read and write.
 - d. Must have at least completed eighth grade.
 - e. Must be able to follow the PCCP with minimal supervision unless there is a change in the participant's condition.
 - f. Current verification of an annual TB Skin Test and CPR certification must be in the employee's personnel record.
 - g. Must have no physical/mental impairment to prevent lifting, transferring, or providing any other assistance to the participant.
 - h. Must assist participant appropriately with daily living activities related to personal care.
 - i. Current verification of an annual TB Skin Test must be in the employee's personnel record.
 - j. Must complete a probationary period determined by the employer with continued employment contingent on completion of personal care in-service training program and participant's satisfaction.
 - k. Must be employed by a certified Home Health Agency or other Health Care Agencies approved by the

Commissioner of the Alabama Medicaid Agency.

1. Services provided by family members or friends may be covered only if the family members or friends meet qualifications for providers of care; there are strict controls to assure that payment is made to the relative or friends as providers only in return for personal care services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The Case Manager must have documentation in the participant's file showing that attempts were made to secure other qualified providers before a family member or friend is considered. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent. The OA is responsible for reviewing these records and verifying there is proper supportive documentation to the lack of qualified providers living in a remote area.

1. Personal Choices participants may hire legally liable relatives, as paid providers of services. However, restrictions do apply on participant living arrangements, when homes or property are owned, operated or controlled by a provider of services, not related by blood or marriage to the participant. (refer to: AL SPA 07-002; Attachment 3.1-A 1915 (J) vi.)

Services must be provided under the supervision of a nurse as noted under 1.a.-e. above.

a. Make visits to the participant's residence after the initial visit by the registered nurse

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Case Manager, the participant and/or a family of legal representative and/or other persons designated by the participant will all meet to develop the PCCP. During the meeting all parties will discuss the needs and vision of the participant, informal supports provided by family or other community resources, and identify the gaps in supports. The Case Manager informs the participant of waiver services and other resources to assist in filling those gaps. The participant decides which personal representative will be involved in development of the plan of care. The PCCP development meeting is designed to increase the participant's self-determination and improve their own independence.

Developing a PCCP will include a comprehensive review of the participant's problems, strengths and weaknesses. Based on identified needs, mutually agreed upon goals are set. This process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized.

Development of the PCCP for all individuals transitioning from the institution is based on individual needs. Development of the PCCP should include participation by the client, the individual's family/sponsor and Case Manager. This process will provide information for all individuals to make informed choices regarding available

community services and support. During the transition period, special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed. The PCCP must be reviewed every 60 days in the presence of the participant to ensure services are appropriate for participant's needs. Informal supports are crucial in supplementing the PCCP. Waiver services cannot be provided 24/7, therefore informal supports are used to ensure health and safety when waiver services are not in the home.

The PCCP development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources.

Service Coordination - will be accomplished by the Case Manager along with input from the participant/family/caregiver, and other involved agencies/parties as needed. All services needed by the participant will be included in the PCCP implemented by the Case Manager.

Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The PCCP and service contracts will be updated to reflect any changes in service needs.

Monitoring - each case will be monitored monthly through contacts and at least one face-to-face visit monthly with the participant. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed. The PCCP must be reviewed every 60 days in the presence of the participant to make sure services are appropriate for participant's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Following referral, intake and temporary case assignment, the Case Manager makes a face-to-face visit with the client for evaluation and completion of the HCBS application. To clarify the assessment information, the Case Manager may consult with the client and/or family, and physician, with regard to medical, behavioral, functional and social information.

Once the Case Manager feels that he or she has adequate information for a level of care determination, an initial PCCP is completed. The HCBS application is reviewed by a Registered Nurse at the Operating Agency's state office for appropriateness of waiver admission. Justification for level of care determination must be properly documented in the client's file.

The Plan of Care encompasses a comprehensive review of the client's problems and strengths. Based on identified needs, mutually agreed upon goals are set. The PCCP development should include participation by the client and/or family/primary caregiver, and Case Manager. The PCCP development process provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized. All waiver and non-waiver services provided to meet a client's needs should be included in the PCCP.

The Case Manager will submit a written Service Authorization Form to the DSP Agency authorizing waiver service (s) and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with

the individual client's needs as set forth in the PCCP.

To coordinate the provision of a direct E/D Waiver service to be delivered at the client's place of residence, an initial visit should be held at the client's place of residence and should include at a minimum the Case Manager, the DSP Supervisor, the client and caregiver as applicable. It is advisable to also include the DSP Worker in the initial visit.

An initial visit is required when a DSP begins to provide services to a client in the client's place of residence. If a client receives more than one direct service from a DSP, only one initial visit is required. If a client has more than one DSP, an initial visit should be conducted with each DSP.

Each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal providers included on the PCCP are delivering the amount and type of services that were committed.

The amount, frequency and beginning date of service depend on the client's needs.

Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing clients according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

Clients and/or responsible relatives shall be instructed to notify the Case Manager if services are not provided as planned, or if the client's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the PCCP. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service authorizations will be updated to reflect any changes in service needs.

Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs. Any change in Waiver Services necessitates a revision of the PCCP. The revised PCCP must coincide with the narrative explaining the change and a new Service Authorization Form should be submitted by the Case Manager to DSP.

If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the PCCP, the DSP will contact the Case Manager to discuss having these duties added.

- (a) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
- (b) The Case Manager will approve any modification of duties to be performed by the Waiver Service Worker and re-issue the Service Authorization Form accordingly.
- (c) Documentation of any change in a PCCP will be maintained in the client's file.
 - (i) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (ii) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (iii) If an individual declines waiver services or has become ineligible for services, a Service Authorization Form indicating termination is required from the Case Manager.
 - (iv) A new Service Authorization is required following each redetermination of eligibility, even if there are no changes to the authorized services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the participant's safety are addressed in the development of the PCCP. Plans are individualized and should take into consideration the participant's rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed, the plan of care adjusted accordingly and evaluated for appropriateness.

During the monthly visit the case manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the PCCP. The case manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered "highly" at risk the case manager may visit more often to monitor the situation to ensure the participant's health and safety is not jeopardized. When a risk has been reported or identified, a home visit to monitor the health and safety of the client is required as soon as it can be arranged.

Additionally, DSP staff must visit the participant's home as ordered in the PCCP. DSPs are trained and expected to observe and report any concerns about a participant's health and welfare to the case manager and in writing to supervision of the DSP agency.

Direct Service Providers have policy/procedures established for serving clients in the event the assigned worker is unable to provide the service. As part of this back-up protocol the DSP's are notified of high risk clients so that any participant designated by the case manager as at risk should be given first priority when service visits must be temporarily prioritized and/or reduced by the DSP

Prior to initiating a service authorization, the case manager must contact the provider to determine the start date and discuss any special needs to the client. Identification is required of the client whose needs are such that the absence of an authorized waiver service would have a substantial impact on the client's health and safety. An emergency backup plan for those applicants who are considered "at risk" if visits are not made. (A disaster preparedness plan should also be in place.) In cases where the client is determined to be at risk for missed visits, the authorization will be flagged when initiated. If the at-risk status changes, the existing authorization is revised and sent to the provider indicating the current status.

An emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a client who would be vulnerable during the emergency/disaster:

(1) Not Priority - Client is not vulnerable during emergency/disaster or has adequate supports to meet his or her needs. (Example: Client with functional deficits, but family willing and able to evacuate and/or meet needs.)

(2) Priority, Client Lives Alone - Client lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Client lives alone and has no one available to evacuate him or her or has no one to give insulin.)

(3) Priority, Advanced Medical Need - Client has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Client is on ventilator, dialysis, or other specialized equipment/service.)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Prior to assessment for the waiver program, the case management staff for the EDW program screens the applicant for their desire for waiver participation and their likelihood to meet financial and level of care eligibility criteria. These activities are preliminary requirements for waiver enrollment and are distinct from case management activities but are

included in this scope of service and are recorded as administrative activities. These activities are documented in the case record.

The intake and screening process is involved and must include documentation regarding the following:

- a. The applicant has been informed about the application process;
- b. The applicant has been informed of all direct service providers and allowed his or her freedom of choice of providers;
- c. The applicant has been informed of all HCBS programs of which he or she may benefit and allowed freedom of choice of programs;
- d. The applicant has been informed of choice options regarding case management services;
- e. The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the client is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The reason for the absence of a signed choice should be well documented in the case record. Signatures with the mark of an X are accepted followed by a statement "Mark of recipient's name" and the mark must be witnessed. If the applicant is physically impaired to the extent that he or she is unable to sign for him or herself, the legal representative may sign the form as follows: "Jack Jones signed by Joe Scott." It must be clearly documented why the applicant did not sign;

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The AMA will conduct a random sample of all Person Centered Care Plans for persons receiving waiver services. The AMA reviews a sample of PCCP's and related documents annually for providers. This assures that the clients that are receiving services under the waiver have a PCCP in effect for the period of time that the services were provided. This review ensures that the need for services that were provided was documented in the plan, and that all service needs were addressed in the PCCP prior to delivery.

A copy of the PCCP is maintained by the case managers, service provider and in the client's home.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The entity responsible for monitoring the implementation of the PCCP and participant health and welfare is the case management staff of the Operating Agency during the face-to-face visit. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the PCCP, and verification that all formal and informal supports included on the plan are delivering the amount and type of services that were committed. The PCCP must be reviewed every 60 days in the presence of the participant to ensure that services are appropriate for the participant's needs. Participant's and/or responsible relatives shall be instructed to notify the Case Manager if services are not initiated as planned, or if the participant's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the PCCP. The OA also conducts random home visits to monitor service plan implementation and assess the health and welfare of participants.

When a participant has been approved for ACT waiver services and the PCCP implemented, or when changes are made to the PCCP, the Case Manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services included in the plan. The Case Manager must ensure that waiver services requested on the Service Authorization Form include only those services contained in the approved PCCP. The DSP must receive documentation regarding the specific needs and desires of the participant and the specific tasks to be performed. Information included on the Service Authorization Form must be clear, specific, accurate and include the number of units or hours of service per day and the number of days per week which are authorized. DSPs are trained and expected to observe and report any concerns in a participant's health and welfare to the Case Manager and in writing to the supervisor of the DSP agency.

The supervisor of the DSP agency has a responsibility to contact case management staff immediately by telephone when services cannot be provided to an at risk participant.

Annual desk reviews are performed by the AMA and include case management personnel files, participant files, and visits to participants in their homes.

Medicaid is informed by the Operating Agency when there is a problem with a participant's service plan. Notification of critical situations is sent to Medicaid via "Critical Events/Incidents" forms. Less critical situations are sent to Medicaid via patient completed survey as well as discussion during home visits by the case manager. Data is evaluated for any type of trend in a participant's service plan. Negative trends could potentially be addressed by: updating the service plan, reevaluating the DSP, or updating primary caregivers and their information. Rectifying problems with a participant's PCCP will be on an individual basis considering the participant's health and safety needs.

The service plans are reviewed by multiple staff at various levels. The participant and Case Manager. The Case Manager and Case Manager Supervisor. If there are concerns at any level of review, feedback is requested from the participant and case manager. Plans are reviewed concurrently with provision of services as well as retrospectively.

- b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and

participant health and welfare may not provide other direct waiver services to the participant.

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Participants who have PCCP's that address their needs and personal goals as indicated by the assessment. N: number of PCCP's reviewed that address participants needs and personal goals as indicated by the assessment. D:Total number of PCCP's reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State

to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of PCCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver.

N: Number of PCCP's reviewed for required participants in the PCCP development process. D: Total number of plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of PCCP's that were revised as warranted before the annual redetermination date. N: Number of revised PCCP's before the annual redetermination date. D: Total number of PCCP's.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who services are being delivered according to the specifications on the PCCP as indicated through the Electronic Visit Verification Management System (EVVM) Report. N: Number of waiver

participants who services are being delivered according to the PCCP as indicated on the EVVM report. D: Total number of waiver participants

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

e. **Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participant records reviewed has a signed freedom of choice form that specifies choice was offered among waiver services and providers.

N: Number of Participant records reviewed with a signed freedom of choice form.

D: Total number of participant record reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
 The Alabama Medicaid Agency (AMA) has granted the OA the authority to develop PCCP's. AMA will conduct retrospective record reviews on a monthly basis. AMA will also review a percentage of case management records on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 The Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency and operated by ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, (3) Conducts quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs and Quality Assurance has developed a Quality Management Strategy for the E&D Waiver Program.

The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant’s homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; and (4) Collect data and submit quarterly and annual reports to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Personal Choices Program State Plan Option will be offered to participants to afford them the opportunity to direct and manage their own services to the extent they are able. If they are unable they may appoint a representative to act on their behalf. The following processes describes the provisions of this program:

Where the PCCP indicates the need for services, each participant will be provided a choice between the traditional vendor or the Personal Choices Option. The participant will share employer authority for the services they choose to

self-direct. During the planning process, services and supports will be identified to meet the participant's individual needs and may include state plan services, generic resources and natural support networks in addition to waiver services. At the time of the planning process, the Case Manager will ensure that the participant and caregiver have sufficient information available to make informed choices about participation in the Personal Choices Program. The Case Manager will also ensure that the participant has the information needed to make informed selections of qualified waiver providers and notify participants about their ability to change providers if they are not satisfied with a provider performance.

Services available for Participant Direction are: Personal Care, Homemaker, Unskilled Respite, and Adult Companion. Personal Choices Program providers must comply with the provisions within the Alabama Nurse Practices' Act.

Participants who choose to self-direct personal care services will be referred to a Financial Management Service Agency (FMSA) that will function as an intermediary between each participant and individuals who perform the self-directed services. The FMSA will assist the participant and/or representative to facilitate employment of direct service providers. The FMSA will conduct the following tasks:

- Identify and recruit individuals or agencies that can provide services;
- Development an enrollment packet for individuals or agencies that will provide services;
- Perform background checks on prospective individuals who will provide services;
- Provide information and training materials to assist in employment and training of workers;
- Facilitate meetings with the participant and the individual or agency providing services;
- Manage and monitor on a monthly basis, all invoices from individual employees who provide waiver services against the amount of services authorized in a particular plan of care;

Participants of the E&D Waiver will be able to access services in two ways:

Option one is the traditional ACT waiver services.

The second option is the Personal Choices Program described under 1915(j) of the Social Security Act, which provides an alternative to the traditional provision for personal care services. The Personal Choices option is available in Alabama. This option follows the agency of choice model, allowing the participant and the FMSA to act as co-employer model in the delivery of personal care services. Under this option, the waiver participant will be responsible for identifying individual to perform their services. The waiver participant will notify the FMSA of their choice of workers for consideration of employment. The FMSA will have the candidate complete an application for employment and will perform the background screening for each candidate prior to employment and provision of service. The review of timesheet will be the responsibility of the waiver participant. The worker will submit completed timesheets directly to the FMSA. The FMSA would be responsible for monitoring all invoices for services. The case manager will monitor the provision of participant-directed services through monthly home visits to ensure services are delivered and health and safety is not compromised. The case manager will also review invoices for accuracy prior to vendor payment. The FMSA will be monitored at least every two years by the OA.

- Develop fiscal accounting and expenditures reports;
- Report problems regarding participant directed services to the ACT Waiver Case Manager;
- Work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's employees;
- Withhold federal, state, and local tax payments including FICA;
- File the necessary tax forms for the IRS and the State of Alabama;
- Provide the individual with the necessary tax information on a timely basis;
- File and withhold state unemployment insurance tax; and
- Make payments for invoices submitted by individuals or agencies providing services.

The Case Manager will conduct an initial orientation that begins with a self-assessment process using the Waiver Consumer Choices Roles and Responsibilities tool which provides a detailed description of the roles and responsibilities and support functions of the Case Manager and the FMSA.

The Personal Choices Program participant may choose to manage their own personal support plans, or may appoint a representative to assist them. All participants have an option of choosing one individual to act as a representative to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

The Alabama Medicaid Agency will maintain oversight of the following FMSA activities:

- Monitor the FMSA to the degree necessary to ensure compliance with appropriate fiscal and programmatic procedures;
- Implement data gathering processes to enable the AMA to create accurate reports to identify and prevent erroneous billing;

-Provide support to the FMSA to facilitate effective training and identify efficient financial accounting methods; and
The AMA will collect information from participants and providers regarding the satisfaction with the FMS' performance. This process may include focus groups, phone contacts and face-to-face interviews.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*
- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
 - Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
 - The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

- d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):
- Waiver is designed to support only individuals who want to direct their services.**
 - The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
 - The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Personal Choices Program participants will be allowed to direct services. Participants may choose to manage their own services or may appoint a representative to assist them. There must be strict controls to ensure that

payment is made to the relatives or friends as providers only in return for personal care services. Those who choose not to direct services will continue to receive their services through the traditional Waiver program.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Case Manager will conduct an initial orientation that begins with a self assessment process using the Waiver Consumer Choices Roles and Responsibilities tool. This tool provides a detailed description of the roles and responsibilities of the participant including a detailed description of the roles, responsibilities and support functions of the Case Manager and the FMSA agency.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.**
- The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants may choose to manage their own personal support plans or may appoint a representative to assist them. All participants have the option of choosing one individual to act as representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Homemaker	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Personal Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Unskilled Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Companion Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The FMSA was selected based upon the State of Alabama's procurement guidelines. The FMSA agency will enroll as a provider. The FMSA will not provide any direct services. The FMSA will operate as a Vendor Fiscal/Employer Agent. The FMSA contractor will provide services in withholding, filing and paying Federal and State income tax withholding, FICA, FUTA and SUTA in accordance with federal IRS and DOL and State of Alabama Departments of Revenue and Industrial Relations rules and regulations. The FMSA will conduct required criminal background checks for all prospective employees of the Personal Choices Program. The FMSA will perform all FMSA tasks directly and may not delegate any FMSA tasks to a third party without expressed written permission from the operating agency.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The FMSA will receive a set monthly payment for each participant per month. This cost is estimated at 15% of the participant's budget. When a participant is enrolled for the first time, the first monthly payment is slightly

higher to cover the administrative costs.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

Specify:

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The OA will monitor the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours. Remediation of the problem will be expected within 48 hours of the FMSA being notified by the operating agency. AMA will be responsible for monitoring this process annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Pursuant to the 1915j: The Case Manager will play a significant role in the overall development of the participant's personal support plan. The Case Manager will continue to assess supports and needs as well as health and safety risks as required by E&D Waiver protocols. The Case Manager will perform a re-assessment of the participant's level of care needs at least semi-annually in order to resolve any identified health and safety issues.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health	<input type="checkbox"/>
Homemaker	<input checked="" type="checkbox"/>
Personal Care	<input checked="" type="checkbox"/>
Skilled Respite	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Unskilled Respite	<input checked="" type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Companion Service	<input checked="" type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Case Manager will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial assessment process, during reviews and updates to the PCCP. If the individual elects to direct their own services, they will be referred to the FMSA to provide employer related services. These include:

- Identifying and recruiting individuals or agencies that can provide personal care services;
- Developing an enrollment packet for individuals or agencies that will provide personal care services;
- Performing background checks on prospective individuals who will provide personal care services;
- Providing information and training materials to assist in employment and training of workers;
- Facilitating meetings with the participant and the individual or agency providing personal care services;
- Managing, on a monthly basis, all invoices for personal care services authorized in the participants' plan of care;

-Developing fiscal accounting and expenditure reports.

The methods and frequency of the FMSA review will be as follows:

- The FMSA will provide monthly reports to the OA
- The OA and/or AMA will perform on-site administrative and operational reviews
- AMA and ADSS will monitor the FMSA, on a monthly basis during the first six months of operations and every six months thereafter.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

L. A program participant may elect to discontinue participation in the Personal Choices Program at any time. The AMA and the OA will initiate procedures to serve as safeguards to ensure that the reasons for discontinuance are not related to abuse, neglect or similar concerns. It is the responsibility of the participant to initiate voluntary discontinuance by notifying the Case Manager of such decision by phone, mail, or e-mail. The Case Manager will document in the participant's record, the date of notification by the participant of their decision to discontinue in the Personal Choices Program. The Case Manager will begin the process within 5 business days from the date of notification.

A face-to-face contact is required to discuss the following:

- To provide an opportunity for the Case Manager to determine if the participant's health, and welfare has been jeopardized during the process
- To identify and resolve any problems that would enable continued participation with the program or confirm that the reasons for discontinuation cannot be resolved.
- To obtain the signature of the participant to attest to his desire to discontinue participation
- To explain the processes and timeline for return to the traditional service delivery option
- To ascertain the participant's choice of direct service provider

From the receipt of the participant's request to discontinue their participation, the timeline for initiation of traditional waiver services may be from 15 to 30 days. The Case Manager will have 5 days to begin the process of reinstating traditional waiver services. Personal Choices Program services will continue until traditional services have been reinstated.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the Personal Choices Program, the participant will be returned to receiving traditional waiver services. Participants will be given advance notice in writing of their return to the traditional program. Although the decision to involuntarily disenroll the participant from the Personal Choices Program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on the appeal. The participant/representative has 15 days from the date of the notification of their return to the traditional waiver program to request an informal review of the decision to disenroll the participant from the Personal Choices Program. The AMA and the OA will make a decision within 30 days from receipt of the request for an informal review.

If the informal review decision is unfavorable, the participant may appeal the decision within 30 days from the date of the written decision of their return to the traditional program in accordance with established Medicaid Fair Hearings provisions.

Participants may be involuntarily returned to traditional waiver services for the following reasons:

-Health, Safety and Well-Being: At any time that the Case Manager or the AMA determines that the health, safety and well-being of the participant is compromised or threatened by continued participation in the Personal Choices Program, the participant will be returned to traditional waiver services.

-Change in Condition: If the participant's ability to direct their own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the individual will be returned to traditional waiver services.

-Under Utilization of Budget Allocation: The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is under utilizing the monthly allocation or is not using the allocation according to their personal support plans, the FMSA and Case Manager will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under-utilization of the budget allocation, the participant will be returned to traditional waiver services.

-Failure to Provide Required Documentation: If a program participant/representative fails to provide required documentation of expenditure and related items as prescribed in the Waiver Consumer Choices Roles and Responsibilities tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program. The participant will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the on Personal Choices Program.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	635
Year 2	<input type="text"/>	875
Year 3	<input type="text"/>	1115
Year 4	<input type="text"/>	1355
Year 5	<input type="text"/>	1595

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The cost of conducting criminal background checks will be compensated as part of the payment to the FMSA.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets
 Discharge staff (common law employer)
 Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the State's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

The Case Manager will assist the participant with their budget. A potential service plan is discussed using current waiver services. An estimate of the total cost of that service plan will be used as the budget for a Personal Choices participant. The participant can arrange their services in a manner that's consistent with their health and safety needs. The participant can not exceed the budget amount that was agreed upon in the service plan, without prior approval. The Case Manager will provide the participant with the information regarding how to request an adjustment to their budget. Participants are made aware of their appeal rights upon admission to the E&D Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The State assures that the methodology used to establish budgets will meet the following criteria:

- A. Each participant's budget will be established based on the current hours of traditional personal care

hours received each week. Of the total monthly amount, a portion will be directed to the FMSA for administration of the participant-directed services. The primary choice for the recipient will be the decision regarding who will provide their services.

- B. The number of hours that a participant will receive is based on the individual assessment of need and will remain unchanged, unless the participant's need changes. All changes will be indicated on the waiver participant's PCCP. Each participant will be provided a form which will assist in determining the payment methodology and rate of pay for the worker.

- Services are reviewed for appropriateness monthly during the case management home visit. Any additional factors identified during the home visit or by other means are based on the assessment of need and will be indicated on the recipient's PCCP.

- D. Policy and procedures will describe the formula used to establish each recipient's budget which will be applied consistently for each recipient who chooses the participant-directed option.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

4/6The State informs each participant of the amount of their monthly budget and the procedures by which to request an adjustment in the budget amount during the development of the personal support plans. Separate orientations to participant direction are provided by the Case Manager during the home visits. As a result, the potential participants are provided timely information about participant direction to allow them to make an informed decision about whether to enroll in the Personal Choices Program. For example, potential participants will be informed about the benefits and responsibilities associated with enrollment into the Personal Choices Programs.

Participants are made aware of their appeal rights upon admission to the E&D Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The financial management activities will include:

- Identification of problems associated with the monthly allowance such as misuse or under-utilization of the funds;
- Participant/representative's failure to pay staff as required;
- Participant/representative's failure to comply with applicable state and federal laws;
- Participant/representative's failure to submit documentation of expenditures;

Theft of checks mailed to participants or other problems will be reported in writing to the AMA and the OA.

The Case Manager will train, coach and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget effectively to meet their care needs, avoid overspending as well as to prevent the under utilization of their allocated budget.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

- a. Description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.

As part of assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

- b. Following is a description of the State's procedures for allowing individuals to choose either institutional or home and community-based services

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the form and has no legal or responsible party who can sign. In such a situation, services will not be denied just because a written choice statement cannot be obtained. The case manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

c. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the case manager discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/ representative.

Whenever there is a decision by the administering agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Operating Agency will issue a written 10 day advance notice to the client and or family/caregiver indicating the client right to a fair hearing and instructions for initiating an appeal and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. A copy of the notice will be forwarded to the Medicaid Agency.

The OA will be responsible for taking a lead role in the fair hearing process by preparing and conducting the fair hearing. Medicaid legal counsel and program staff will function as support staff. If the individual/guardian is still dissatisfied after the fair hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The State operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency does operate another dispute resolution process, the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a fair hearing. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the case manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing.

At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within thirty (30) days of the date of the notice of action. The document referring to the participant's appeal rights is maintained in the waiver participant's home for future reference.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama

Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of Federal or State law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The following State Agencies are responsible for the operation of the grievance/complaint system:

1. Alabama Department of Senior Services(ADSS)

2. Alabama Medicaid Agency(AMA)

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ADSS is responsible for explaining the procedures to clients of filing complaints and grievances. ADSS must also have procedures in place that will assure AMA that DSP have explained to clients the process on how to register a complaint. Waiver applicants/participants are informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility. Written information is maintained in the participant's home about this process as well. The DSP supervisor will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or AMA.

a. Complaints are submitted to ADSS or the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions in the AMA Quality Improvement Coordination Unit. The OA will also maintain a log of complaints and grievances received.

b. If complaints are received by the AMA, a copy will be forwarded to ADSS within two (2) working days. If they are received by ADSS a copy will be forwarded to AMA LTC Program Management Unit within two (2) working days if the client's health and safety are at risk. Otherwise, the complaint/grievance should be entered on the quarterly log that is submitted to AMA.

c. ADSS must investigate all complaints upon receipt of notification. Appropriate parties must initiate action within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed.

d. A summary and plan of correction will be sent from the OA to the AMA Quality Improvement Coordination Unit for all complaints reported within 30 days of the request for the summary or plan of correction from the AMA. The providers must forward their plan of corrections to the OA who will in turn forward to AMA. The OA will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the provider within two (2) days. The revised plan of correction will be resubmitted to the OA

within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the provider will have up to seven (7) days to revise the plan and carry out the appropriate action.

e. ADSS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risk exist.

f. Final determinations including any adverse findings will be reported to the AMA, LTC Program Management Unit.

g. The AMA will contact the client via telephone or targeted survey to ensure full resolution to the incident has been completed in a satisfactory manner.

h. On a quarterly basis, ADSS will forward all grievance logs to AMA Quality Improvement Coordination Unit for review, tracking, and assurance that resolutions have been completed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

Definitions

Physical Abuse-the infliction of physical pain, injury or the willful deprivation by a care giver or other person of necessary services to maintain physical and mental health.

Sexual Abuse—any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include rape, incest, sodomy, and indecent exposure.

Verbal Abuse—the infliction of disparaging and angry outbursts such as name calling, blaming, or accusatory comments.

Neglect—the failure of a caregiver to provide food, shelter, clothing, medical services, or healthcare for the person unable to care for himself or herself; or the failure of the person to provide these basic needs for himself or herself when the failure is the result of the person's mental or physical inability.

Mistreatment—Actions that cause harm or create serious risk of harm whether intended or not, to a vulnerable person, by the caregiver or another person, or failure of a caregiver to satisfy the basic need or to protect the child or adult from harm.

Death—the permanent suspension of consciousness and the end of life.

Exploitation—the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Moderate Injury—any observable and substantial impairment of a person's physical health such as temporary loss or impairment.

Major Injury—any observable and substantial impairment that results in permanent or temporary impairment, such as fractures, injury to internal organs, burns, or physical disfigurement of the body. These injuries may result in hospitalization.

Natural Disaster—the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.

Fire— a situation in which something such as a building or an area of land is destroyed or damaged by burning.

Fall— an incident that causes a person to drop suddenly from an up-right position which may result in harm.

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human Resources, law enforcement authorities, physicians, caregiver's individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976

All physicians, osteopaths, chiropractors and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

Other incidents such as falls must be reported within 24 hours to the Provider Agency, the Alabama Medicaid Agency, and the Alabama Department of Senior Services in a timely manner based upon the circumstances surrounding the incident.

Child Abuse Prevention and Treatment Act 1974

Alabama law is clear on reporting abuse and neglect of children under the age of 18. For example, physicians, teachers, social workers, nurses, day care workers or anyone who comes in contact with suspected child abuse or neglect should make a report to those who can take action. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that a child has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the State Child Abuse Reporting Hotline (334- 242-9500).

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with consumers to encourage them to talk about what is important to them as well as what they do not like. Each recipient is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the recipient's rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand. The case manager and the DSP is responsible for informing the client/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect/ or exploitation.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Alabama Department of Senior Services is the entities that receive reports of critical events or incidents. The operating agency (OA) will investigate the critical events reported and make a decision within seven (7) working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse require an investigation. If the OA determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and arrange when appropriate. Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Alabama Department of Senior Services is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants through individual/family interviews. The operating agency will notify Medicaid's E & D Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken. In addition, Medicaid's Quality Improvement Coordination Unit is responsible for overseeing the reporting of and response to critical incidents through a review of quarterly participation satisfaction surveys, a review of complaint logs, medical record reviews, DSP personnel record reviews, and onsite home and provider visits, when deemed necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Alabama Department of Senior Services (ADSS): Monthly monitoring of participants health and welfare and provider quality reviews.

The Department of Human Resources (ADHR): certain incidents of abuse, neglect and exploitation must be reported to ADHR by law.

The Alabama Medicaid Agency: Annual review of ADSS investigations.

- **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.
 - i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Alabama Department of Senior Services is responsible for detecting the unauthorized use of restrictive interventions through monthly face to face visits as well as supervisory visits every 60 days

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The State does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. **Applicability.** Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the

performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of critical incidents, by type, that were reported, investigated, and completed within the required time frame as specified in the waiver. N: Number of critical incidents, by type, that were reported, investigated, and completed within the required time frame. D: Total number of critical incidents.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of satisfaction survey respondents who reported that their health and safety needs are being met. N: Number of survey respondents who reported that their health and safety needs are being met. D: Total number of survey respondents.

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participant records reviewed that indicated a report of instances of abuse, neglect, and/or exploitation that also had corresponding resolution. N: Number of participant records reviewed that indicated a report of instances of abuse, neglect, and/or exploitation that also had corresponding resolution. D: Total number of critical incident reports.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of provider files that document training and education was provided to Case Management and service provider staff on how to identify and address health concerns of a participant. N: Number of provider files reviewed that document training and education was provided to Case Management and service provider staff. D: Total staff files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Case Manager will monitor participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager will also report any events of this nature to the waiver administrator in the approved format who will forward to AMA within the required guidelines. The Case Manager will track reports to resolution for documentation and will report the resolution to the waiver administrator to forward to AMA.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information

on the methods used by the State to document these items.

The Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, and (3) Conducts quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs.

AMA has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; and (4) Collect data and submit quarterly and annual reports to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

When complaints and grievances arise every attempt is made to resolve them at the local level. When this effort is not successful the grievance process is initiated. Waiver participants are encouraged to advise the case manager of any dissatisfaction relative to any aspect of the care or services received through the E&D Waiver. Clients may register a complaint or grievance relating to denial, reduction or change in waiver services, financial eligibility, Direct Service Providers, Direct Service Workers or with the case manager. If the complaint or grievance is lodged against the case manager the operating agency is responsible for resolving the concerns. If the complaint or grievance is lodged against the operating agency the Medicaid Agency is responsible for resolving the concerns.

If complaints are received by the Medicaid Agency, a copy will be forwarded to E&D Waiver program administrator within two (2) working days. All complaints are investigated upon receipt of notification. Appropriate parties must initiate follow-up within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed. A summary and plan of correction will be developed by the Medicaid Reviewer for complaints reported with the exception of those reported to the Direct Service Provider (DSP) Agency. The DSP must forward their summaries and plans of correction to the Medicaid Agency, who will in turn forward them to the AIDS Waiver program administrator for review. The administrator will evaluate the plans of correction within seven (7) days of receipt. If the plan of correction submitted by the DSP Agency is found not to be responsive to the complaint, the administrator will return the plan to the DSP Agency requesting a resubmitted plan within two (2) working days of receipt of notice. If the summary or plan of correction carried out by the DSP Agency continues to be unresponsive, the DSP Agency will have up to forty-five (45) days to revise the plan and carry out the appropriate action. Final determinations including any adverse findings will be reported to the E&D Waiver program administrator. The Medicaid Agency will contact the client via telephone to ensure full resolution to the incident has been completed satisfactory.

Complaints received by the Medicaid Agency will be submitted to the operating agency within 2 working days. If complaints are submitted to the OA, Medicaid must be notified within 2 working days after the complaint is received. The OA must investigate all complaints upon receipt of notification. Appropriate parties must take action if it appears that a recipient's health and safety is at risk within 24 hours. In these cases, the Medicaid Agency must be notified within one (1) working day of the action taken. The complainant will be interviewed if necessary. A summary and plan of correction will be sent from the OA or the provider for all complaints reported to the Medicaid Agency Quality Assurance Division. The Medicaid Agency will evaluate the plan of correction. If the plan of correction is not responsive to the complaint it will be returned to the OA. The corrective plan of correction will be sent to the Medicaid Agency within 2 working days. The Medicaid Agency will contact the recipient and/or responsible party and the case manager via telephone to ensure full complaint resolution has been reached.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
 Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Description of the Quality Management Program for the Elderly and Disabled Waiver

The Quality Management Strategy for the Elderly and Disabled (E & D) Waiver is:

AMA is responsible for collecting data quarterly and annually regarding the quality of services provided from various sources for the E & D Waiver program. The Quality Framework is used as a guide to assess seven (7) Program Design Focus areas from samples of waiver participants, case management and direct service providers' records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, consumer satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine clients' satisfaction with resolutions.

- ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Data is collected through an annual review of each operating agency which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all applicants approved by the AMA is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of case managers and other employees' personnel records are reviewed to ensure basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months until they are found to be in compliance.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

AMA will evaluate reports and make recommendations for improvements to the program. The AMA will determine if changes are made to the program. In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access:

Sources of data
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant –Centered Service Planning and Delivery:

Sources of data
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities:

Sources of data
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards:

Sources of data
Case Management Records
Consumer Surveys

Home Visits
Site Visits

Participants Rights and Responsibilities:

Sources of data
Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction:

Sources of data
Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance:

Sources of data
Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborated Meeting with Operating Agency to enhance the administration of
the Program
Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaid's Long Term Care Division:

- Percentage of client/family reporting satisfaction with waiver services and needs met.
- Percentages of client/family reporting they feel safe and secure in the home and community.
- Percentage of client/family reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of client/family reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the client's needs and preferences.
- Evidence that each operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that each operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

On October 1, 2017, the Alabama Medicaid Agency will implement an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's Electronic Visit Verification and Monitoring System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

How does the EVVM system work?

1. When a service is authorized for a member, a schedule can be entered into the EVVM system.
2. The provider agency employee (worker) arrives at the member location to provide a service.
3. The worker checks into the system using the following:

The worker's mobile device to log the visit using the EVVM app (or the recipient phone will be utilized to dial into the Interactive Voice Response (IVR) system as the authorized back-up method).

The worker enters their worker ID, selects the recipient and the service they are going to perform.

4. Using GPS technology, the location from which the service is rendered is validated.
5. The system verifies that the worker is appropriate to provide the prior authorized service for the member and advises the worker that he/she is checked in.
6. After the worker performs the service, the worker checks out using the same process and indicates specific tasks performed.
7. Claims will be available for the provider's review via the EVVM system website in real-time.
8. After the provider's review, the provider should confirm the claim.
9. Once confirmed, claims are automatically submitted for payment.

Medicaid's post-payment financial audit program for the E & D Waiver is designed to ascertain that only reasonable and allowable expenses are included in the cost reports received from the operating agencies. Cost reports are due to Medicaid no later than 90 days after the fiscal year end. An audit of the cost reports is conducted annually. These audits are limited in scope. The basis for the audit is a comparison of Medicaid's adjudicated claims file to the provider's cost report. The auditor will conduct a sampling process of the provider's expenditures. The sample includes, but is not limited to; provider contracts, cost allocation, previous audits, cash disbursements, general ledger accounts, cash receipts, verification of deposits, payroll records including employee time sheets and cancelled checks, vendor invoices, and all vouchers or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditor's findings and opinion regarding compliance and internal control. After the sample is completed, the auditor will make adjustments to the cost report if necessary. The provider's adjusted cost report is compared to Medicaid's paid claims file for final settlement.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The AMA has contracted with a fiscal agent to maintain the payment records on services received and billed under the E&D Waiver. The OA ensures that all services and corresponding payments are coded and documented properly. The OA ensures that only those services included on the plan of care are billed for the E&D Waiver participant.

On October 1, 2017, the Alabama Medicaid Agency will implement an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. Medicaid's Electronic Visit Verification and Monitoring System is an electronic scheduling, tracking, reporting and billing system for in-home care providers. This paperless, web-based system also provides real-time access to information needed for member services management.

How does the EVVM system work?

1. When a service is authorized for a member, a schedule can be entered into the EVVM system.
2. The provider agency employee (worker) arrives at the member location to provide a service.
3. The worker checks into the system using the following:
 - The worker's mobile device to log the visit using the EVVM app (or the recipient phone will be utilized to dial into the Interactive Voice Response (IVR) system as the authorized back-up method).
 - The worker enters their worker ID, selects the recipient and the service they are going to perform.
4. Using GPS technology, the location from which the service is rendered is validated.
5. The system verifies that the worker is appropriate to provide the prior authorized service for the member and advises the worker that he/she is checked in.
6. After the worker performs the service, the worker checks out using the same process and indicates specific tasks performed.
7. Claims will be available for the provider's review via the EVVM system website in real-time.
8. After the provider's review, the provider should confirm the claim.
9. Once confirmed, claims are automatically submitted for payment.

The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and E&D Waiver eligibility before the claims are paid. The AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.

To ensure maximum reimbursement to services providers, the AMA is notified of any claims payment issues and will work with the OA and the fiscal intermediary to resolved the issues.

The AMA through the Decision Support System can generate adhoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information

on the methods used by the State to document these items.

The Elderly and Disabled Waiver (E&D) is administered by the Alabama Medicaid Agency (AMA) and operated by ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, (3) Conducts quarterly meetings to disseminate policies, rules and regulations regarding the home and community-based waiver programs and, (4) signs all qualified direct service providers contracts enrolled with ADSS to provide waiver services.

The AMA has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates for E & D Waiver services are established by Medicaid. They are prospective rates that are based on audited historical costs with consideration given to the health care index and renegotiated contracts. Medicaid pays private and public contractors the same rate. An OA may request an interim increase or decrease at any time. If approved by Medicaid, the adjusted rate allows claims to be paid at a rate that is closer to the provider's actual cost. If a rate adjustment is retroactive, previously paid claims are recouped and repaid at the adjusted rate. At fiscal year end, the total amount paid by the OA is divided by the total number of units served, and an average rate per service is determined. Medicaid uses the average rate to determine the final settlement.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

As each waiver year is audited, this cost like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost. Cost Reports from the OAs are due to Medicaid by December 31. Cost settlements are made no later than September 30 of the following year.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Each waiver participant, once approved, is added to the Alabama Medicaid's Long Term Care File. This file holds approved dates of eligibility for waiver services.

Providers billings flow directly from the providers to the Medicaid MMIS through the Fiscal Intermediary as follows:

- Payments made by Medicaid to providers are on a cost reimbursement basis. Each covered service is identified on a claim by a HCPC code.
- For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. Each service type is identified by Procedure Code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.
- If the submitted claims covers dates of service where part, or all of which were covered in a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.
- Payment is based on the number of units of service reported on the claim for each procedure code.
- Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.
- All claims must be filed within twelve months from the date of service. Medicaid recovers payments that exceed actual allowable cost.
- Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**

- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the HCPC code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims

(including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid

agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Alabama's Area Agencies on Aging (local government) provides Case Management services for the E&D Waiver.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ADSS

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- This waiver is a part of a concurrent 1115/1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The source of non-federal funds for the E&D Waiver is the general fund appropriations to ADSS. These funds are 106, general fund; 349, other funds such as federal, intergovernmental transfers, drug rebates, and other small amounts; 564, Health Care Trust Funds for provider taxes; and 1047, tobacco revenue. These funds are for the sole use of Medicaid once the appropriation is made by the Legislature. The Alabama Legislature does not line item budget any revenue or expenditures for Medicaid. In other words, no revenue comes to Medicaid earmarked for certain expenditures. It is up to Medicaid how a voucher is coded and thus charged. If Medicaid has any balance in fund 106 at the end of the year, it does not revert back to the State general fund.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Intergovernmental transfers from State Agency providers of waiver services.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
- i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. **Co-Payment Requirements.**
- ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. **Co-Payment Requirements.**
- iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	7018.18	7343.00	14361.18	40968.00	2616.00	43584.00	29222.82
2	7018.18	7490.00	14508.18	41787.00	2668.00	44455.00	29946.82
3	7018.18	7640.00	14658.18	42623.00	2722.00	45345.00	30686.82
4	7018.18	7793.00	14811.18	43475.00	2776.00	46251.00	31439.82
5	7018.18	7949.00	14967.18	44345.00	2832.00	47177.00	32209.82

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	9355		9355
Year 2	9355		9355
Year 3	9355		9355
Year 4	9355		9355
Year 5	9355		9355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay is derived by dividing the total number of days in a waiver year by the total number of clients served. This information is based on data in the CMS-372 Report for year 2015 (10/1/14 through 9/30/15). Submitted and approved in 2017.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is derived from data shown by the CMS-372 Report, Waiver #0068, for Waiver Year 2015, with a 2 percent inflation factor applied to each year of the renewal period.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from data shown by the CMS-372 Report, Waiver #0068, for Waiver Year 2015, with a 2 percent inflation factor applied to each year of the renewal period.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from data shown by the CMS-372 Report, Waiver #0068, for Waiver Year 2015, with a 2percent inflation factor applied to each year of the renewal period.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from data shown by the CMS-372 Report, Waiver #0068, for Waiver Year 2015, with a 2 percent inflation factor applied to each year of the renewal period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Health
Case Management
Homemaker
Personal Care
Skilled Respite
Companion Service
Home Delivered Meals
Unskilled Respite

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							359936.00
Adult Day Health	<input type="checkbox"/>	Day	100	148.00	24.32	359936.00	
Case Management Total:							19049118.75
Case Management	<input type="checkbox"/>	15 min	9355	181.00	11.25	19049118.75	
Homemaker Total:							19158851.50
Homemaker	<input type="checkbox"/>	15 min	6812	779.09	3.61	19158851.50	
Personal Care Total:							12691363.20
Personal Care	<input type="checkbox"/>	15 min	5020	687.00	3.68	12691363.20	
Skilled Respite Total:							2612611.60
Skilled Respite	<input type="checkbox"/>	15 min				2612611.60	

			262	1460.00	6.83		
Companion Service Total:							439351.44
Companion Service	<input type="checkbox"/>	15 min	264	461.00	3.61	439351.44	
Home Delivered Meals Total:							5787869.30
Home Delivered Meals	<input type="checkbox"/>	14/wk	4843	37.00	32.30	5787869.30	
Unskilled Respite Total:							5555931.52
Unskilled Respite	<input type="checkbox"/>	15 min	1286	1174.00	3.68	5555931.52	
GRAND TOTAL:							6565033.31
Total: Services included in capitation:							
Total: Services not included in capitation:							6565033.31
Total Estimated Unduplicated Participants:							9355
Factor D (Divide total by number of participants):							7018.18
Services included in capitation:							
Services not included in capitation:							7018.18
Average Length of Stay on the Waiver:							301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							359936.00
Adult Day Health	<input type="checkbox"/>	Day	100	148.00	24.32	359936.00	
Case Management Total:							19049118.75
Case Management	<input type="checkbox"/>	15 min	9355	181.00	11.25	19049118.75	
Homemaker Total:							19158851.50
Homemaker	<input type="checkbox"/>	15 min	6812	779.09	3.61	19158851.50	
Personal Care Total:							12691363.20
Personal Care	<input type="checkbox"/>	15 min	5020	687.00	3.68	12691363.20	
Skilled Respite Total:							2612611.60
Skilled Respite	<input type="checkbox"/>	15 min	262	1460.00	6.83	2612611.60	

Companion Service Total:							439351.44
Companion Service	<input type="checkbox"/>	15 min	264	461.00	3.61	439351.44	
Home Delivered Meals Total:							5787869.30
Home Delivered Meals	<input type="checkbox"/>	14/wk	4843	37.00	32.30	5787869.30	
Unskilled Respite Total:							5555931.52
Unskilled Respite	<input type="checkbox"/>	15 min	1286	1174.00	3.68	5555931.52	
GRAND TOTAL:							65655033.31
Total: Services included in capitation:							
Total: Services not included in capitation:							65655033.31
Total Estimated Unduplicated Participants:							9355
Factor D (Divide total by number of participants):							7018.18
Services included in capitation:							
Services not included in capitation:							7018.18
Average Length of Stay on the Waiver:							301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							359936.00
Adult Day Health	<input type="checkbox"/>	Day	100	148.00	24.32	359936.00	
Case Management Total:							19049118.75
Case Management	<input type="checkbox"/>	15 min	9355	181.00	11.25	19049118.75	
Homemaker Total:							19158851.50
Homemaker	<input type="checkbox"/>	15 min	6812	779.09	3.61	19158851.50	
Personal Care Total:							12691363.20
Personal Care	<input type="checkbox"/>	15 min	5020	687.00	3.68	12691363.20	
Skilled Respite Total:							2612611.60
Skilled Respite	<input type="checkbox"/>	15 min	262	1460.00	6.83	2612611.60	
Companion Service Total:							439351.44

Companion Service	<input type="checkbox"/>	15 min	264	461.00	3.61	439351.44	
Home Delivered Meals Total:							5787869.30
Home Delivered Meals	<input type="checkbox"/>	14/wk	4843	37.00	32.30	5787869.30	
Unskilled Respite Total:							5555931.52
Unskilled Respite	<input type="checkbox"/>	15 min	1286	1174.00	3.68	5555931.52	
GRAND TOTAL:							65655033.31
Total: Services included in capitation:							
Total: Services not included in capitation:							65655033.31
Total Estimated Unduplicated Participants:							9355
Factor D (Divide total by number of participants):							7018.18
Services included in capitation:							
Services not included in capitation:							7018.18
Average Length of Stay on the Waiver:							301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							359936.00
Adult Day Health	<input type="checkbox"/>	Day	100	148.00	24.32	359936.00	
Case Management Total:							19049118.75
Case Management	<input type="checkbox"/>	15 min	9355	181.00	11.25	19049118.75	
Homemaker Total:							19158851.50
Homemaker	<input type="checkbox"/>	15 min	6812	779.09	3.61	19158851.50	
Personal Care Total:							12691363.20
Personal Care	<input type="checkbox"/>	15 min	5020	687.00	3.68	12691363.20	
Skilled Respite Total:							2612611.60
Skilled Respite	<input type="checkbox"/>	15 min	262	1460.00	6.83	2612611.60	
Companion Service Total:							439351.44
Companion Service	<input type="checkbox"/>	15 min	264	461.00	3.61	439351.44	

Home Delivered Meals Total:							5787869.30
Home Delivered Meals	<input type="checkbox"/>	14/wk	4843	37.00	32.30	5787869.30	
Unskilled Respite Total:							5555931.52
Unskilled Respite	<input type="checkbox"/>	15 min	1286	1174.00	3.68	5555931.52	
GRAND TOTAL:							65655033.31
Total: Services included in capitation:							
Total: Services not included in capitation:							65655033.31
Total Estimated Unduplicated Participants:							9355
Factor D (Divide total by number of participants):							7018.18
Services included in capitation:							
Services not included in capitation:							7018.18
Average Length of Stay on the Waiver:							301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							359936.00
Adult Day Health	<input type="checkbox"/>	Day	100	148.00	24.32	359936.00	
Case Management Total:							19049118.75
Case Management	<input type="checkbox"/>	15 min	9355	181.00	11.25	19049118.75	
Homemaker Total:							19158851.50
Homemaker	<input type="checkbox"/>	15 min	6812	779.09	3.61	19158851.50	
Personal Care Total:							12691363.20
Personal Care	<input type="checkbox"/>	15 min	5020	687.00	3.68	12691363.20	
Skilled Respite Total:							2612611.60
Skilled Respite	<input type="checkbox"/>	15 min	262	1460.00	6.83	2612611.60	
Companion Service Total:							439351.44
Companion Service	<input type="checkbox"/>	15 min	264	461.00	3.61	439351.44	
Home Delivered Meals Total:							5787869.30

Home Delivered Meals	<input type="checkbox"/>	14/wk	4843	37.00	32.30	5787869.30	
Unskilled Respite Total:							5555931.52
Unskilled Respite	<input type="checkbox"/>	15 min	1286	1174.00	3.68	5555931.52	
GRAND TOTAL:							65655033.31
Total: Services included in capitation:							
Total: Services not included in capitation:							65655033.31
Total Estimated Unduplicated Participants:							9355
Factor D (Divide total by number of participants):							7018.18
Services included in capitation:							
Services not included in capitation:							7018.18
Average Length of Stay on the Waiver:						<input type="text" value="301"/>	301