Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

State:	
Effective Date	

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 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.

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1. Request Information

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*): Community Waiver

C. **Type of Request:** *(the system will automatically populate new, amendment, or 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**
X	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

D. **Type of Waiver** *(select only one)*:

☐	**Model Waiver**
X	**Regular Waiver**

E. **Proposed Effective Date:** 7/1/2020

Approved Effective Date *(CMS Use)*:

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:

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	☐	**Inpatient psychiatric facility for individuals under age 21 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**
X	**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 facility level of care:	

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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§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:*
X	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
X	**A program authorized under §1115 of the Act.** *Specify the program: Community First*

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

X	**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.

This waiver, operated concurrently with 1115 authority ("Community First" demonstration waiver), enables the state to provide a range of HCBS to individuals with intellectual disabilities, ages 3 to no limit, who meeting institutional level of care but who wish to receive HCBS. This waiver has deeming options by which it can reach children at home with their families and adults with unearned income of up to 300% of the SSI maximum.

This waiver will initially operate in five pilot areas of the state, including one from each existing service delivery region. With a waiver under 1115 authority, Support Coordination will be provided exclusively by the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH/DDD). In addition, this waiver offers services and supports for waiver participants and their families, customized to the waiver participant's living situation, identified goals and assessed needs related to these goals, including health and safety needs and risk planning and mitigation needs. The goals for this waiver include: (1) preserving an individual's existing living arrangement, including preserving family living arrangements where both the family and the individual desire this but need supports to achieve this; (2) increasing access to competitive integrated employment opportunities and effective services and supports to enable waiver participants to obtain and maintain competitive integrated employment; (3) for individuals who are not able to live with family, providing opportunities for individuals to reside in their own home as the first option; increasing opportunities for self-direction while ensuring appropriately trained self-direction workers; (5) providing other innovative supportive services that individuals and their families say they need most including transportation, peer-to-peer and family assistance with navigating systems and accessing community resources, a breaks & opportunities service (respite), and personal assistance and/or skill-building services available both at and in the community. The waiver design and service array also assist the state in ensuring compliance with the HCBS Settings Rule, the Americans with Disabilities Act and other applicable federal laws and regulations.

The waiver will be operated by the ADMH/DDD through an MOU/operating agreement with the Alabama Medicaid Agency (AMA) which will oversee ADMH/DDD is carrying out all aspects of waiver administration. Service delivery will be through a provider network contracted by ADMH/DDD which will have responsibility for recruitment, certification or verification of required qualifications through other means, contracting, and ongoing quality monitoring and quality assurance activities. ADMH/DDD shall also have responsibility for development of rate methodologies and payment rates for services, and ongoing review of such methodologies and rates for appropriateness to achieve the goals of the waiver and ensure an adequate, quality provider network. ADMH/DDD shall be responsible for receiving, approving, processing and paying all claims from providers with administrative oversight from AMA

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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)*:

X	**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**
X	**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**
X	**Yes**

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

X	**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*:
	Five (5) pilot counties, one in each of ADMH/DDD's five operating regions. Five specific counties to be determined through RFP process for willing and qualified providers. RFP responses due 3/13/20 and selection expected to be completed by 3/31/20. Public comments are encouraged with regard to selection of the five pilot geographic areas of the state.
☐	**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.

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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 Improvement Act of 2004 (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 in-patients 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 throughout the application and in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The state initially utilized stakeholder listening sessions, conducting 11 sessions between December, 2019 and April, 2019. At least two sessions were held in each region of the state. Invitations were again sent to individuals receiving waiver services, those on waiting lists, their families and advocates. Using this input, the state produced a "Concept Paper" for this new waiver program. The state held a thirty-day public comment period for the Concept Paper in July, 2019. During this time, the state also held 5 stakeholder engagement sessions, one in each region of the state. At each session, a presentation on the Concept Paper was done followed by an opportunity for stakeholders to provide input and recommendations regarding the new waiver program. Finally, the state posted this application for a thirty-day public comment period on 3/6/2020 as required under federal regulations. Waiver participants, those on the waiting list, their families, advocates and the general public were notified of the public comment period on this waiver application by Provider Alert, Posting to AMA website, notification to DMH listserv notification to AMA listserv.

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 as 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:	Wettingfeld				
First Name:	Ginger				
Title:					
Agency:	Alabama Medicaid Agency				
Address :	501 Dexter Avenue				
Address 2:	P. O. Box 5634				
City:	Montgomery				
State:	Alabama				
Zip:	36103-5624				
Phone:		**Ext:**			**TTY**
Fax:					
E-mail:	Ginger.Wettingfeld@medicaid.alabama.gov				

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

Last Name:	La Porte				
First Name:	James				
Title:	Interim Director of System Transition and Waiver Development				
Agency:	Alabama Department of Mental Health/Division of Developmental Disabilities				
Address:	100 North Union Street				
Address 2:	P.O. Box 301410				
City:	Montgomery				
State:	AL				
Zip :	36130-1410				
Phone:	251 478 2766	**Ext:**			**TTY**
Fax:	251 450 3798				
E-mail:	James.laporte@region3.mh.alabama.gov				

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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:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:					
First Name:					
Title:					
Agency:					
Address:					
Address 2:					
City:					
State:					
Zip:					
Phone:		**Ext:**			**TTY**
Fax:					
E-mail:					

Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH Waiver)

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

This is a new waiver. Two existing 1915(c) waivers for people with intellectual disabilities (Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities AL.0001 and Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities AL.0391) will remain open for those enrolled as of the date this new 1915(c) waiver opens. No new enrollments will occur into the Living at Home Waiver (AL.0391). New enrollments to the Intellectual Disabilities Waiver (AL.0001) will be limited only to crisis enrollments (reserve capacity slots) in areas of the state where this new 1915(c) waiver is not operating. After this new 1915(c) waiver has been in operation for two calendar

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years, the state will allow voluntary transitions of individuals enrolled in the Living at Home or Intellectual Disabilities Waiver, with funding to follow each individual that transfers to this new 1915(c) waiver. Individuals who may voluntarily transfer to this new waiver will have ninety (90) days from date of enrollment in this new 1915(c) waiver to opt to transition back to the 1915(c) waiver from which they moved, if they desire to do so. After ninety (90) days, the slot will be permanently transferred to this new 1915(c) waiver.

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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.

The state assures that this waiver will be subject to any provisions or requirements included in the state's most recent and approved home and community-based setting Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan. Additionally, for this waiver, the state assures that no setting will be utilized that is not fully compliant with the requirements of the HCBS Settings Rule or that was an approved HCBS setting prior to March 17, 2014 and that has a state-approved transition-to-compliance plan in place that will bring the setting into full compliance by March 17, 2022.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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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)*	
X ☐	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 Mental Health, Division of Developmental Disabilities		
	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).*		

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.

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:

Through a memorandum of understanding (MOU) Medicaid designates the Alabama Department of Mental Health (ADMH) as its agent responsible for all of the functions identified in Appendix A.7. of this application. As the Oversight agency, the Alabama Medicaid Agency ensures that the:

*Operating agency adheres to all federal guidelines described in the approved waiver document

*Health and safety of the client is protected

*Client has been given freedom of choice between institutional care and community care

*Direct service providers meet the qualifications as outlined in the approved waiver document; and signs all subcontracts of qualified direct service providers enrolled with the operating agency.

*Individuals served are aware of their rights to express concerns regarding service provision and/or direct service providers.

The Medicaid Agency provides ongoing oversight of this waiver program by assuring level of care determinations, plans of care, and other necessary documentation is correctly submitted and reviewed. This is accomplished by a direct review of a random sample of application and renewal documents per month.

In addition, the Medicaid Agency maintains ongoing oversight and authority over the program by:

*Conducting joint training with direct service providers enrolled to provide services through the Community waiver program.

*Participating in training provided periodically by the operating agency to discuss policies and procedures in an effort to consistently interpret and apply policies related to the Community waiver program.

*Conducting annual training for all operating agency staff to disseminate policies, rules and regulations regarding the home and community-based waiver programs.

*Performing annual reviews conducted by LTC Quality Assurance Unit to assure the provisions of the interagency agreements are executed and all the assurances in the waiver are being met. The reviews include, but are not limited to provider's records, plans of care, staff qualifications and training, and case management services and monitoring.

*Annual reviews of Quality Enhancement Plan and Activities, quarterly review of complaints made to the Office of Advocacy, including the resolution of same, and participation in stakeholder task forces to assure that proposed improvements meet Medicaid requirements.

*Establishing policies and procedures for operating agency, direct service providers and targeted case managers to ensure services are provided as specified in the approved waiver document.

*Conducting desk reviews of all provider agencies serving sampled Community Waiver participants.

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*):

X	**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.*
	In order to implement self-directed services, two Financial Management Services Agencies (FMSA) are utilized. These contracted entities provide fiscal intermediary and other services to participants who choose to self-direct some of their services. The two FMSAs were selected by a competitive RFP process. They are Allied Group and PCG/Public Partnerships. The services of the FMSA are described in detail in Appendix A.7. and Appendix E, which will include assuring "Qualified Provider Enrollment" and "Execution of Medicaid Provider Agreements."
	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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)*:

X	**Not applicable**
	Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	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*:

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:

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:

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	X☐	X☐	☐	☐
Waiver enrollment managed against approved limits	X☐	X☐	☐	☐
Waiver expenditures managed against approved levels	X☐	X☐	☐	☐
Level of care evaluation	X☐	X☐	☐	☐
Review of Participant service plans	X☐	X☐	☐	☐
Prior authorization of waiver services	X☐	X☐	☐	☐
Utilization management	X☐	X☐	☐	☐
Qualified provider enrollment	X☐	X☐	X☐	☐
Execution of Medicaid provider agreements	X☐	X☐	X☐	☐
Establishment of a statewide rate methodology	X☐	X☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	X☐	X☐	☐	☐
Quality assurance and quality improvement activities	X☐	X☐	☐	☐

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:	Percent of data reports specified in the agreements, policies and procedures with the Medicaid Agency that were submitted on time and in the correct format. Percentage = NUMERATOR [Number of data reports provided timely and in the correct format] / DENOMINATOR [Number of data reports due]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Data reports submitted to the Medicaid Agency	

State:	
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	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Percent of total reported performance measures that were below 86%. Percentage = NUMERATOR [Number of performance measures that were below 86%] / DENOMINATOR [Number of reported performance measures]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Performance measure reporting	

State:	
Effective Date	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of requested reports submitted by the OA reviewed and validated by the AMA Program Manager for program compliance. Percentage = NUMERATOR [Number of OA submitted reports reviewed and validated by the AMA Program Manager for waiver compliance] / DENOMINATOR [Number of reports submitted by the OA]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Performance Measure Reporting	

State:	
Effective Date	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of self-directed employees/staff that have a Provider Enrollment Agreement with the FMSA, thus complying with state regulations and agreeing to AL Medicaid oversight. Percentage = NUMERATOR [Number existing self-directed employees/staff that are enrolled with FMSA] / DENOMINATOR [Number of existing self-directed employees/staff]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

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FMSA data				
	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)*	
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*	
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*	
	☐ Sub-State Entity	*☐ Quarterly*		*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*☐ Annually*		
		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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 has an established methodology for aggregating data from multiple sources and weighting it to rate performance within a specific domain. The methodology was designed through a

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collaborative effort between the AMA and consultants at Navigant.

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.

All measures are shared with the operating agency in quarterly reports, and are presented with reference to baseline data from previous periods. The goal is to improve the scores, but if they stay the same or decrease slightly, it does not require corrective action. Significant drops from baseline, as determined by the Medicaid Agency, will require follow-up, and a plan of correction.

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)*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other Specify:	*X Annually*
		☐ Continuously and Ongoing
		☐ 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 Administrative Authority that are currently non-operational.

x☐	**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.

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Appendix B: Participant Access and Eligibility

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select One Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
x☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	x☐	Mental Retardation	3		x☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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)*:

x ☐	Not applicable. There is no maximum age limit

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☐	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:

Appendix B-2: Individual Cost Limit

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)*:	
x ☐	**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.**	

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	☐	**The following percentage that is less than 100% of the institutional average:**		
	☐	**Other:** *Specify:*		

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:

a. The prioritization used for the waiting list indicates the services which the person is likely to need and gives an initial indication of who is likely not to need to exceed the cost limit.
b. The education done prior to enrollment lays out the various services available and how they can be used to meet people's needs in the most cost-effective ways, thus ensuring needs can be addressed both effective and cost-effectively, allowing most all individuals to be served within the cost limit.
c. The planning team understands the limitation and will not proceed, without requesting prior authorization for services in excess of the cost limit (as described in section B.2.c below), if the cost of the most cost-effective services necessary to meet an individual's needs will exceed the limit. There is also flexibility for specific services selected, and the scope of the coverage most often will allow the planning team develop a plan within the individual cost limit.
d. The plan of care is assessed for cost and assistance with appropriately revising the plan in a way that is acceptable to the individual will be provided to the planning team if it exceeds the limit.
e. For individuals with plans that include services subject to rate increases in a future waiver renewal or amendment application, if the individual cost limit will be exceeded due to the rate increases, and not because additional services are added or additional units of service for services already in the plan are added, the cost limit may be exceeded by the amount of the calculated rate increases to accommodate the impact of these rate increases for as long as this continues to be necessary to ensure no reduction in service utilization must occur if there has been no reduction in assessed need.
f. To prevent institutionalization, the planning team can request prior authorization for services in excess of the cost limit (as described in section B.2.c below) if those services are both effective and the most cost-effective in meeting the individual's needs.

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.**
X ☐	**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:
	The assigned Support Coordinator for the individual, who conducts all assessments and assists and facilitates the work of the person-centered planning team, is responsible for submitting a Preliminary Notification of Needs Potentially Exceeding Individual Cost Limit form to their Regional Office Supervisor and to the Central Office Waiver Director. This will trigger

	involvement and consultation with the planning team by the Regional Office Supervisor and/or the Central Office Waiver Director who will do a comprehensive review of the individual's record, including all history, assessments and person-centered planning information. Should the conclusion be reached that the cost for the cumulative total of needed effective and most cost effective services will exceed the individual cost limit, a plan of care including these services, in appropriate amount, frequency and duration will be developed with the individual. The plan of care will be submitted to the Assistant Commissioner for the Division of Developmental Disabilities who will review and approve the plan of care for a one-year period, including the amount by which it exceeds the individual cost limit. For the purposes of preventing institutionalization, a plan of care that exceeds the individual cost limit can be approved with services in an amount that does not exceed 24/7 provision of an appropriate intensity of supports, 365 days per year, if needed.
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

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	474
Year 2	705
Year 3	936
Year 4 (only appears if applicable based on Item 1-C)	1368
Year 5 (only appears if applicable based on Item 1-C)	1584

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)*:

X	**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	

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Year 4 (only appears if applicable based on Item 1-C)	
Year 5 (only appears if applicable based on Item 1-C)	

State:	
Effective Date	

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.**		
X☐	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for:		
	Table B-3-c		
		Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
		Children in State Care/Custody	Emergency Placements
		Purpose (describe):	**Purpose** (describe):
		Children with intellectual disabilities come into the State's care and custody due to family inability to cope, usually with behavior, in addition to the other pressures that tend to overwhelm families with special needs children. The State's Children Service Agency (The Alabama Department of Human Resources, or DHR) ordinarily finds foster homes for such children, but sometimes the behavior and other conditions are more than a foster home can manage and the child must either be placed in an institution by court order, or in the home and community-based waiver as a court-accepted alternative.	New admissions to the waiver who would otherwise be homeless or subject to abuse or neglect, or in significant danger of harm from other sources and require immediate intervention.
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
	Waiver Year	The number of children entering from this source has been consistent for several years, averaging 25/year statewide. The proposed pilot area for this waiver is	ADMH/DDD continues to encounter emergency situations, however, based on the average number over the last 4 years, the number has been decreased based on utilization. Since this time we

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		estimated to cover 50% percentage of the state's total need; therefore, 12 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.	have made updates in our process to serve people in a high risk situation. Due to this adjustment the State projects a need to reserve 35 slots per year, statewide, for individuals in this category. The proposed pilot area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 18 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.
		Capacity Reserved	**Capacity Reserved**
	Year 1	12	18
	Year 2	12	18
	Year 3	12	18
	Year 4 (only if applicable based on Item 1-C)	12	18
	Year 5 (only if applicable based on Item 1-C)	12	18

◯	**Not applicable. The state does not reserve capacity.**		
X ◯	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for:		
	Table B-3-c		
		Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
		Transitions from LAH Waiver	Outplacements from Nursing Homes or Institutions
		Purpose (describe):	**Purpose** (describe):
	Waiver Year	Participants Transferring from the Living at Home Waiver when their needs can no longer be safely and appropriately met in that waiver.	Institutionalized individuals have a right, with some limitations, to be placed in the community, in accordance with the Olmstead Decision. This reserve capacity is to ensure

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			state has sufficient "slots" to serve people who wish to move to the community.
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
		Data for several years has indicated an average of 25 transfers per year from the Living at Home Waiver to the ID Waiver. With programming changes at the Medicaid Fiscal Agent and a waiver amendment, Disabled Adult Children (DACs) are now able to remain on the Living at Home Waiver with income up to 300% above of the SSI FBR. This has significantly reduced the number of individuals who have to transfer out of the LAH waiver. The statewide reserved capacity has been reduced accordingly to 15 slots. The proposed pilot area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 8 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.	Because the State has eliminated state run institutions for individuals with intellectual disabilities, the demand for outplacement is currently solely based on Skilled Nursing Facilities and occasional transition from an institution where placement may occur. The State projects it needs to reserve 10 slots each year, on a statewide basis. The proposed pilot area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 5 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.
		Capacity Reserved	**Capacity Reserved**
	Year 1	8	5
	Year 2	8	5
	Year 3	8	5
	Year 4 (only if applicable based on Item 1-C)	8	5
	Year 5 (only if applicable based on Item 1-C)	8	5

◯	**Not applicable. The state does not reserve capacity.**

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X ◯	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for:		
	Table B-3-c		
		Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
		Transitions to Enrollment Group #4 from Enrollment Groups #1, #2 or #3	
		Purpose (describe):	**Purpose** (describe):
		Participants transferring within the waiver from Enrollment Groups #1, #2 or #3 to Enrollment Group #4 when their needs can no longer be safely and appropriately met in their enrollment group and/or they require out-of-home placement with an intensity of supports that is not available in their enrollment group.	
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
	Waiver Year	The closest equivalent historical situation is transfers from the LAH Waiver to the ID Waiver. Data for several years has indicated an average of 25 transfers per year from the LAH Waiver to the ID Waiver. With programming changes at the Medicaid Fiscal Agent and a waiver amendment, Disabled Adult Children (DACs) are now able to remain on the LAH Waiver with income up to 300% above of the SSI FBR. This has significantly reduced the number of individuals who have to transfer out of the LAH waiver. The statewide reserved capacity for the ID Waiver for this purpose has been reduced accordingly to 15 slots.	

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		The proposed pilot area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 8 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.	
		Capacity Reserved	**Capacity Reserved**
	Year 1	8	
	Year 2	8	
	Year 3	8	
	Year 4 (only if applicable based on Item 1-C)	8	
	Year 5 (only if applicable based on Item 1-C)	8	

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):*

X	**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:

X	**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:

Standard Operating Procedures for enrolling functionally and financially eligible individuals into this waiver have been developed and involve the use of the following steps and enrollment priority

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categories, consistent with the goals of this waiver, the overall Community Waiver program of which this waiver is part, and the state legislature's intent in funding the Community Waiver program including this waiver:
Enrollment Priority Category #1: On waiting list, live in pilot area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment if under age 65.
Enrollment Priority Category #2: On waiting list, live in pilot area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation.
Enrollment Priority Category #3: Not on waiting list but apply through ADMH/DDD, live in pilot area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment if under age 65.
Enrollment Priority Category #4: Not on waiting list but apply through ADMH/DDD, live in pilot area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation.
Enrollment Priority Category #5: On waiting list; live in pilot area where this waiver is operating; transition age 16-21 (EPSDT, public education/special education, ADRS pre-employment transition services still available); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment at exit from high school.
Enrollment Priority Category #6: Not on waiting list but apply through ADMH/DDD; live in pilot area where this waiver is operating; transition age 16-21 (EPSDT, public education/special education, ADRS pre-employment transition services still available); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment at exit from high school.
Additional enrollment priority categories will be developed, with stakeholder input and as needed, if slots remain after the above categories are implemented.

Reserve capacity slots are available to enroll any functionally and financially eligible individual into this waiver, who lives in the pilot area where this waiver is operating, when that individuals makes him/herself known to ADMH/DDD and is determined to meet the definition of a reserve capacity category.

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B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

☐	Phased-in
☐	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

State:	
Effective Date	

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

	No
X	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		
X	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 (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
	Working individuals with disabilities who buy into Medicaid (TWWIIA 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)		

X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:
	435.110- Parents and Other Caretaker Relatives- MAGI pdf S25 435.116- Pregnant Women- MAGI pdf S28 435.118- Infants and Children under Age 19 – MAGI pdf S30 435.227- Children with Non IV-E Adoption Assistance (Over age 21)- MAGI pdf S53 435.150- Former Foster Care pdf S33 435.110 Attachment 2.2A pg 1 435.145 Attachment 2.2A pg 14 435.222 Reasonable Classification of Individuals under Age 21- pdf S52, S11 435.228 Children with Non IV-E Adoption Assistance pdf S53 "individuals deemed eligible for SSI under"; 435.122 435.134 435.135 435.137 435.138

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.
X	**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
X		Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
	X	A special income level equal to (select one):
		X 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 percentage:
		Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
		Medically needy without spend down 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)

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☐	Aged and disabled individuals who have income at: *(select one)*		
	☐	100% of FPL	
	☐	%	of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:		

State:	
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Appendix B-5: Post-Eligibility Treatment of Income

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.

X	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 ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
		Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
X	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-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b-1. 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*):				
X	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:		
	X	**Other standard included under the state Plan** 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.		
	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:			
	Other Specify:			

ii. Allowance for the spouse only (*select one*):	
X	**Not Applicable**
Specify the amount of the allowance (*select one*):	
	SSI standard
	Optional state supplement standard

State:	
Effective Date	

☐	**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:*		

iii. Allowance for the family *(select one)*:

X☐	**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:

X☐	**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*:

State:	
Effective Date	

State:	
Effective Date	

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
☐	The following standard included under the state plan *(select one)*			
	☐	The following standard under 42 CFR §435.121 *Specify*:		
	☐	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 percentage:	
		☐ $	A dollar amount which is less than 300% of the FBR 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*:			
☐	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
☐	Not Applicable (see instructions)			
☐	The following standard under 42 CFR §435.121 *Specify:*			

State:	
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☐	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*:		

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 §435.735:

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 checked.*
☐	The state does not establish reasonable limits.
☐	The state establishes the following reasonable limits *(specify)*:

State:	
Effective Date	

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

State:	
Effective Date	

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. 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** $ ____ If this amount changes, this item will be revised.
  Specify dollar amount:
- ☐ **The following formula is used to determine the needs allowance:**
  Specify:
- ☐ **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:

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Specify the amount of the allowance (*select one*):	
☐	**SSI standard**
☐	**Optional state supplement standard**
☐	**Medically needy income standard**
☐	**The following dollar amount:** $ If this amount changes, this item will be revised. Specify dollar amount:
☐	**The amount is determined using the following formula:** *Specify:*
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**

State:	
Effective Date	

	Specify:

State:	
Effective Date	

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

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts 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):
  - ☐ **The following standard under 42 CFR §435.121:**
    Specify:
  - ☐ **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:
- ☐ **Other**
  Specify:

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

- ☐ **Not Applicable**

State:	
Effective Date	

☐	**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:*

Specify the amount of the allowance (*select one*):

☐	**The following standard under 42 CFR §435.121:** *Specify:*		
☐	**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:*		

iii. <u>Allowance for the family</u> (*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

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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*:

State:	
Effective Date	

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).

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**		
☐	%	Specify percentage:	
☐	**The following dollar amount:**	$	If this amount changes, this item will be revised
☐	**The following formula is used to determine the needs allowance:** *Specify formula:*		
☐	**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.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

State:	
Effective Date	

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §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*):

- [X] 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:
  - [X] **Other standard included under the state Plan**
    Specify:

    The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 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.
- [ ] **The following dollar amount** $ If this amount changes, this item will be revised.
  Specify dollar amount:
- [ ] **The following formula is used to determine the needs allowance:**
  Specify:
- [ ] **Other**
  Specify:

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

- [ ] **Not Applicable**
- [X] **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:

State:	
Effective Date	

	The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 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.
X☐	**The amount is determined using the following formula:** *Specify:*		
	The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 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. <u>Allowance for the family</u> (*select one*):			
X☐	**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:			
X☐	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*		

State:	
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☐	**The state does not establish reasonable limits.**
☐	**The state establishes the following reasonable limits** *Specify*:

State:	
Effective Date	

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

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts 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):

☐ **The following standard under 42 CFR §435.121:**
Specify:

☐ **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:

☐ **Other**
Specify:

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

☐ **Not Applicable**

State:	
Effective Date	

☐	**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:*

Specify the amount of the allowance (*select one*):

☐	**The following standard under 42 CFR §435.121:** *Specify:*		
☐	**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:*		

iii. <u>Allowance for the family</u> (*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

State:	
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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*:

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**		
☐	%	Specify percentage:	
☐	**The following dollar amount:**	$	If this amount changes, this item will be revised
☐	**The following formula is used to determine the needs allowance:** *Specify formula:*		
X☐	**Other** *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.		

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:

X☐	**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:

State:	
Effective Date	

X	**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.

State:	
Effective Date	

Appendix 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 waiver 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: 1	
ii.	**Frequency of services.** The state requires (select one):	
	☐	**The provision of waiver services at least monthly**
	X ☐	**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: Quarterly.

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

☐	**Directly by the Medicaid agency**
X ☐	**By the operating agency specified in Appendix A**
☐	**By a government agency 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:

State:	
Effective Date	

Support Coordinators employed by ADMH/DDD collect, develop and submit evaluation materials and assessment information to a QIDP in the Operating Agency's Regional Office, who makes the eligibility determination. The Support Coordinator is, at minimum, a person who has a Bachelor of Arts or a Bachelor of Science degree, in a human services-related field, with twenty-four (24) or more months experience working with vulnerable population(s) in community settings. The QIDP in the Operating Agency's Regional Office makes the determination based, at minimum, on the information from a psychologist (psychological evaluation) and the Support Coordinator.

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.

Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disabilities with an age of onset prior to age 18, and significant functional limitations in three (3) of six areas (6) of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press). If necessary, to support a conclusive determination, an ABS will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual. Although persons as young as three years of age can be admitted to the waiver, available state plan and EPSDT services must be utilized for all participants who are under 21 years of age.

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.**
X ☐	**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.
	The same level of care evaluation form was used for both institutional and waiver services, but the information from which adaptive functioning scores were obtained differed. Adaptive functioning level for institutional (ICF/IID) eligibility was determined using the ABS. The ICAP domain scores were specifically modified by one of the authors of the ICAP to meet the requirements of Alabama's definition and to match the outcomes of the ABS. The only difference between the two instruments is that the ABS does not use maladaptive behavior as a factor, and the ICAP does. The State recognizes the ICAP for determining adaptive limitations unless there is a doubt that the person would be

	eligible in an ICF/IID due to the predominance of maladaptive behavior in a qualifying, but borderline, ICAP service score. Currently, the Department of Mental Health does not operate state funded ICF/IID.

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:

The five regional community services offices of ADMH (Operating Agency) are the designated points of application to the Department of Mental Health for this waiver. The regional community services (RCS) office Waiting List Coordinators conduct outreach and process applications for enrollment in the Community Waiver.

A QIDP in the RCS office reviews the results of all test and assessment information accompanying the application and determines the eligibility of all individuals seeking Community Waiver services.

The information needed to determine a person's eligibility for the waiver includes the Level of Care Evaluation (based on full scale IQ, the age of onset, and an ICAP functional assessment). In addition, medical information is submitted, and a criticality assessment is submitted and entered into a data base. If the submitted test/assessment information is not complete or is inconclusive regarding the type or level of disabilities of the individual, the RCS office QIDP will request additional tests/assessments. Notification of need for additional tests, assessments or other information stops the level of care determination process until the additional information has been received.

Applicants who are determined eligible are placed on the waiting list. Using the enrollment priority categories for this waiver discussed in section B.3.f, individuals on the waiting list meeting criteria for an enrollment priority group are contacted by the RCS office Waiting List Coordinator in order of their rank, as determined by their criticality assessment score, which factors in length of time waiting. When an enrollment slot exists, and a person confirms they meet an eligibility priority category, enrollment is completed. The enrollment process includes education on choice to ensure a person wishes to receive HCBS rather than institutional services (signature on Choice Form), education on due process to educate the applicant of his her right to due process (signature on Due Process Rights Form), and the Individual and Family History. The individual also signs an initial Plan of Care that includes Support Coordination and the person is assigned, or as far as possible able to select, a Support Coordinator. Additional forms are required if the applicant is not already Medicaid eligible.

Annual re-determinations must include, along with the Person-Centered Plan and Plan of Care, information to re-determine the level of care:

a. Written reference to and update of the original psychological evaluation which documented the applicant's intellectual disabilities or of a more recent full assessment, all documents to be kept on file and produced if requested.
b. An ICAP administered within the previous twenty-four (24) months (2 years).
c. An annual medical report must be on file.
d. A Individual and Family History updated within 90 days of re-determination.

The regional community services (RCS) office of the Operating Agency, once appropriate documentation is approved, submits the Waiver eligibility decision and enrollment information to Central Office of the Operating Agency. Central Office submits the information electronically to the AL Medicaid's fiscal

intermediary to register the person in the long-term care system as a recipient of Waiver services and retrieves the enrollment dates. This eligibility enrollment is good for 12 full months and then redetermination of eligibility must occur.

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**
X ☐	**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)*:

X ☐	**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)*:

The initial eligibility enrollment is good for 12 full months, but then has to be resubmitted. Without the electronic resubmission and registration, claims for subsequent service dates will fail. Likewise, the Plan of Care is effective for 12 months, and Support Coordinators maintain a schedule for when they have to submit redetermination packets and assist individuals to remain eligible for the waiver.

In order to assist the Support Coordinators, the Division has designed several prompts in the information system that will remind him/her of a pending redetermination due. First, the information system is designed to electronically prompt the Support Coordinator with a "tickler", when there is a redetermination due. The tickler system is set up to generate a redetermination notification, which launches 330 days after the previous redetermination or initial application. Additionally, there are two reports that the Support Coordinator, his/her supervisor, and the RCS office staff can run, filtered by enrollment start and end dates, which will list all the individuals that should be redetermined during the specified dates and will also identify individuals whose redetermination are overdue. The first report, Redeterminations Due, will list all individuals that need to be redetermined within the report dates based on the Waiver enrollment dates. Support Coordinators are encouraged to run this report 90, 60, or 45 days in advance and to begin the redetermination paperwork within 60 days of the individual's eligibility expiration date. The second report, Redeterminations Overdue, works the same way but presents a list of individuals that have not been redetermined, but should have been based on enrollment dates. This report will give the Division the ability to track overdue re-determinations in a more efficient manner and

follow-up as needed. There are times when redeterminations are delayed for documentation purposes; but in the event that someone failed to complete a redetermination on time, this report will capture that information.

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:

Records are maintained by the Operating Agency's Regional Offices.

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/reevaluating 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.

i. 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 applicants who have a level of care (LOC) completed prior to entry into the waiver.

State:	
Effective Date	

	Percentage = NUMERATOR [Number of eligible applicants who receive a LOC evaluation] / DENOMINATOR [Total number of eligible applicants]
Data Source *(Select one) (Several options are listed in the on-line application):*	
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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of applicants who received a physician or Qualified Intellectual Disabilities Professional certification certifying that without HCBS the patient would require nursing facility care or ICF/IID.

State:	
Effective Date	

	Percentage = NUMERATOR [Number of applicants who received a physician or Qualified Intellectual Disabilities Professional certification certifying that without HCBS the patient would require nursing facility care or ICF/IID] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
HCBS Admission and Evaluation Data Form; ICF/IID level of care form	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

State:	
Effective Date	

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

i. 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.

Add another Performance measure (button to prompt another performance measure)

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

i. 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 initial LOC determinations where the instrument and process were accurately applied. Percentage = NUMERATOR [Number of initial LOC determinations where the instrument and process were accurately applied] / DENOMINATOR [Number of initial LOC determinations reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Level of care documentation	

State:	
Effective Date	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.*

State:	
Effective Date	

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.*

Problems regarding individual participants' initial Level of Care are currently handled on an individual basis by RCS office staff of the operating agency. Resolution of these problems requires manual intervention. There is no Medicaid funding paid for someone not in active status with the Medicaid Fiscal Agent as of the date of service and no individual will be enrolled without a LOC, so there is never an issue of payments made incorrectly.

The RCS office has designated staff trained to review all supporting documentation that feeds into the Level of Care form. An assessment in the information system will capture review results. A report will aggregate the data results to reveal patterns where success is less than 86%. Intervention, in general, will consist of:

a. Bringing the data to the attention of those responsible for the discovered areas of weakness.
b. When data shows consistent problems over two consecutive quarters, technical assistance / training will be provided to those at the point of weakness.
c. If no improvement is seen in the next quarter after the intervention, a plan of correction will be required.

ii Remediation Data Aggregation

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

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)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	X Operating Agency	☐ *Monthly*
	☐ *Sub-State Entity*	*X Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

State:	
Effective Date	

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-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).

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

As part of initial and annual assessment, person-centered planning and updating of the plan of care, participants (and their legal representatives, if applicable) are provided with adequate information on the full range of services available under the Community First Waiver program, the services offered through Support Coordination and through other generic programs and public systems with which Waiver services are coordinated. Rights protections and opportunities assured through the HCBS Settings Rule are explained including the choice of settings where services can be delivered. This process enables the individual (and their legal representative if applicable) to make an informed decision regarding the choice to receive home and community-based services. This process may also include opportunities to meet and talk with Waiver service providers and sharing of information on satisfaction with Waiver services among those already enrolled in the Waiver. All individuals are provided choice among service providers in the area. If any needs cannot be met, these also are discussed with the individual and his family to ensure they are fully informed and are aware of other ways to get these needs met, if such alternatives exist. Individuals indicate they have received this information by signing the Freedom of Choice form.

2. Freedom of Choice: being given the choice of either institutional or home and community based services.

Each person enrolled in the Waiver must indicate in writing their choice of institutional or home and community-based services, 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 (or making his/her mark) on the Freedom of Choice and Plan of Care form and has no legal or responsible party who can sign. In such a case, the Support Coordinator must document the reason(s) for absence of a signed Freedom of Choice and Plan of Care form and attest to the above process having been undertaken with the person.

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.

State:	
Effective Date	

Records are maintained by the Operating Agency's Regional Offices.

State:	
Effective Date	

Appendix B-8: Access to Services by Limited English Proficient 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 an estimated 4.1%.

State:	
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Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	X	Support Coordination
Homemaker		
Home Health Aide		
Personal Care	X	Personal Assistance-Home
Adult Day Health		
Habilitation		
Residential Habilitation	X	Community-Based Residential Services
Day Habilitation	X	
Prevocational Services	X	Integrated Employment Path Services
Supported Employment		Supported Employment Small Group
Education		
Respite		Breaks and Opportunities
Day Treatment		
Partial Hospitalization		
Psychosocial Rehabilitation		
Clinic Services		
Live-in Caregiver (42 CFR §441.303(f)(8))		

Other Services *(select one)*	
	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the state requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Personal Assistance - Community

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b.	Community Transportation
c.	Remote Supports
d.	Assistive Technology – Adaptive Aids
e.	Supported Employment Individual Services
f.	Co-Worker Supports
g.	Community Integration Connections and Skills Training
h.	Independent Living Skills Training
i.	Peer Support
j.	Family Empowerment and Systems Navigation Counseling
k.	Natural Support or Caregiver Education and Training
l.	Financial Literacy and Work Incentives Benefits Counseling
m.	Counseling and Assistance with Alternatives to Full Guardianship
n.	Positive Behavior Supports
m.	Supported Living Services
o.	Minor Home Modifications
p.	Housing Counseling Services
q.	Housing Start-Up Assistance
r.	Supported Living Services
s.	Adult Family Home
t.	Physical Therapy
u.	Occupational Therapy
v.	Speech and Language Therapy
w.	Skilled Nursing Services
x.	Individual-Directed Goods and Services
Extended State Plan Services *(select one)*	
☐	Not applicable
☐	The following extended state plan services are provided *(list each extended state plan service by service title)*:
a.	
b.	
c.	

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Supports for Participant Direction *(check each that applies))*	
☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
X☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
☐	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		
c.		

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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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Support Coordination**

Enrollment Group(s): Essential Family Preservation Supports

Seamless Transition to Adulthood Supports

Family, Career and Community Life Supports

Supports to Sustain Community Living

Definition:

A case management and comprehensive supports/services coordination role involving direct assistance with gaining access to waiver program services that are desired by and selected by the individual, from among available services that are effective options for meeting one or more assessed needs. Support Coordination also involves the effective coordination of waiver program services with other Medicaid-funded services, other publicly-funded services and programs (e.g. ADRS, school, workforce and generic community services), and other generic community services and resources (e.g. social, educational, religious, etc.) available to the individual, and family as applicable, regardless of the funding source.

Support Coordinators are responsible for:

- Conducting a comprehensive assessment of the individual, using both strengths and needs-based assessment tools provided by DDD, in collaboration with the individual and others that know the individual well;
- Engaging with the individual (and legal representative/involved family members, as applicable) to accurately identify the individual's vision for his/her life and key goals/outcomes the individual wants to achieve;
- Providing education to individuals (and legal representatives/involved family as applicable) about the various services and supports available through the waiver that are effective options for

enabling the individual to achieve each of the key goals/outcomes identified by the individual (and legal representative/involved family members, as applicable);

- Providing education to individuals (and legal representatives/involved family as applicable) about the option to self-direct certain services and supports that are available through the waiver;
- Providing education to individuals (and legal representatives/involved family as applicable) about the available providers for each service and support available through the waiver;
- Coordinating a person-centered planning process, consistent with the HCBS Settings Rule requirements, and developing a written person-centered plan (PCP), utilizing a template provided by DDD, which defines and documents:
  - The individual's goals/outcomes desired by the individual as part of his/her vision for a good and full life;
  - The individual's needs related to achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life;
  - The natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her with achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life;
  - The types and amounts of waiver services and supports that are needed, in addition to the natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her, in order to ensure the individual can achieve his/her identified goals/outcomes which are considered necessary for achieving his/her vision for a good and full life;
  - The setting in which the individual chooses to receive each waiver service, chosen from among setting options that are also documented in the PCP, including at least one non-disability specific setting option for each service;
  - The individual's choices regarding the option to self-direct certain services and supports that are included in the PCP;
  - The individual's choice of provider for each service and support included in the PCP that will not be self-directed;
  - Ensuring the person is aware of their rights, including choice of providers. Secures the person's signature on the Free-Choice of Qualified and Contracted Providers form and provides the Due Process Rights Form;
  - Any modification(s) to HCBS Setting Rule requirements that may be necessary consistent with federal requirements for including such modification(s) in the PCP;
- Undertaking ongoing monitoring of the provision, adequacy, quality and effectiveness of waiver services/supports included in the person's PCP and progress toward goals/outcomes documented in the PCP;
- Undertaking ongoing monitoring of the person's health, safety and welfare;
- Providing ongoing support and information, as needed, to individuals (and legal representatives/involved family as applicable) who choose to self-direct certain services and supports that are included in the PCP;
- Coordinating services and supports over time, which preserve the individual's ability to live in a community setting;
- Conducting evaluations specified by DDD related to continued functional and financial eligibility for the waiver; and
- There is a requirement of at least one (1) face-to-face visit with the person each month during the first twelve (12) months of enrollment and then quarterly after that time period, in addition to any other Support Coordination activities.

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

- From the person-centered planning process, informed by the requisite assessments, the individual and the SC identify supports and services to address desired goals and outcomes. The individual and Support Coordinator first explore unpaid and natural supports, then supports and services from other systems and programs available to the individual, followed by services and support funded by the waiver program, utilizing waiver funding as the funding source of last resort. When considering waiver services, the Support Coordinator is required to assist the individual in evaluating the waiver services and supports that will most effectively meet the individual's desired goals, outcomes and needs. Support Coordinators are trained to be skilled in explaining services and supports, including those available through generic community resources and other systems and programs.
- Support Coordinators are required to document the individual's goals/outcomes, needs and preferences that are identified through a collaborative review of assessment results and exploratory discussion involving the individual's person-centered planning team. Prior to concluding the PCP development process, Support Coordinators must review their documentation of all of the planning conversations with the individual to ensure the PCP meets all of the person's identified needs and preferences related to their identified goals and outcomes.
- When an individual chooses not to address one of their needs or preferences on the PCP, the Support Coordinator discusses this choice with the individual. If the individual elects to not address an identified need or preference through the waiver PCP, this conversation must be documented, including the Support Coordinator's effort to encourage the individual to address the need. In cases wherein the unaddressed need is related to health and safety or presents another type of risk, the Support Coordinator completes the document, "Risk Agreement – Waiver Program" with the individual to document information and resources provided to the individual.
- Support Coordination Supervisors (SCS) are required to ensure that the PCP's developed by their Support Coordinators meet the needs of the individual as required by this waiver and waiver program policy and work instructions.
- Person Centered Plans are subject to continuous revision, as needed. However, at a minimum, the PCP is reviewed by the individual and SC during a formal review at least annually. During this time, the individual's progress on the goals and outcomes identified on the previous year's PCP is reviewed as a priority. The individual and Support Coordinator collaborate to ensure the new PCP is an accurate and current reflection of the individual's goals/outcomes and needs related to these goals/outcomes, and that the PCP adequately supports the individual's goals and outcomes with waiver–funded services used to wrap around generic community services and supports and services and supports available through other programs and systems. When the cost of an individual's needs exceed the person's expenditure cap, the Support Coordinator is required to involve their Supervisor to review the PCP and assist the individual, as needed, in completing documentation for approval to exceed the expenditure cap (or receive approval for a one-time emergency expense) to avoid enrollment in an enrollment group with a higher expenditure cap, particularly to avoid residential placement if the person is living with natural supports or living independently.
- Through the SC's monthly and quarterly contacts, the SC will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring for the individual and being effectively addressed by the person's providers of waiver services and supports.
- It is also the SC's responsibility to review the provider's submitted documentation at least monthly, and note any problems, concerns, discrepancies, dramatic changes or other occurrences that would indicate a need for review of the provider's performance or the individual's

goals/outcomes or needs. The SC's review of the provider documentation will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk and/or if services are not being delivered according to the PCP.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Alabama Dept. of Mental Health

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Support Coordinator	None	None	Bachelor's degrees in human services field and 24 months or more of experience working with vulnerable populations in community settings(s). Preference will be given for experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities as detailed in the service definition. Human Service field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill Development, or Basic Human Care Needs.

State:	
Effective Date	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Support Coordinator	ADMH DDD	Initially upon hire

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Personal Assistance-Home**

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A range of services and supports designed to complement but not supplant natural supports and assist an individual with a disability to perform, in his/her home, activities of daily living, including instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability. Personal Assistance-Home services are provided in the person's home and outside the home on the property where the home is located. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Home provider in a manner that supports and enables the individual to acquire, retain and maximize skills and abilities to achieve the highest level of independence possible.

Personal Assistance-Home may be used to support the person in preparing for competitive integrated employment (i.e. getting ready for work) and in being transported to this employment.

State:	
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Eligible Personal Assistance-Home services include the following:

- Assistance, support and partial participation, as appropriate to the individual, with eating, toileting, personal hygiene and grooming, dressing and other activities of daily living or instrumental activities of daily living, as appropriate and needed to sustain community living.
- Meal preparation, homemaker tasks, and home chore services, specific and necessary for the waiver participant, involving the waiver participant to the greatest extent possible; other instrumental activities of daily living (e.g. assistance with managing finances (when not managed by a representative payee, legal guardian, financial power of attorney); home-based support for communication including phone, internet use); and other appropriate activities falling under instrumental activities of daily living, as described in the participant's Person-Centered Plan.

Services, if needed, to support goals and needs related to instrumental activities of daily living that occur outside the home (e.g. shopping; banking), competitive integrated employment and community participation, involvement and contribution must also be addressed in the Person-Centered Plan using Personal Assistance-Community, other appropriate services, or available natural supports. Natural supports must be documented in the Person-Centered Plan and confirmed by the Support Coordinator.

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

- This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time.
- This service shall not supplant or duplicate Personal Care services available through the Alabama Medicaid State Plan for waiver enrollees under age 21.
- This service is not available when another covered service is being provided and the assistance available through Personal Assistance-Home is a component part of this covered service. Support Coordinator monitors will review service delivery records to ensure that Personal Assistance-Home is not delivered concurrent with Employment Supports, Breaks and Opportunities (Respite), Supported Living Services, Adult Family Home, or Community-Based Residential Services.
- Authorization based on individual assessment results which account for the availability of sustainable natural supports; 243 hours/month (972 units) maximum and expenditure cap for enrollment group also applies.
- Using self-direction, this service can be provided by a natural caregiver(s) or relative(s) living in the same residence with the person if all of the following are true:
    - The participant is twenty-one (21) years of age or older; and
    - The natural caregiver or relative being paid to provide this service is not also the legal guardian (or Medicaid representative for self-directed services) for the participant; and
    - The natural caregiver is otherwise qualified and capable of providing the care and assistance needed;
    - The participant is not also receiving this service from a paid provider (either agency or through another self-direction worker).

  If the above requirements are met, this service shall not supplant natural supports provided by the

natural caregiver(s) or relative(s) living in the same residence with the person. To ensure such natural supports are not supplanted, the following limitations apply to Personal Assistance-Home, when provided by a natural caregiver(s) or relative(s) living in the same residence with the person:

- Maximum of 486 units per month (This is 50% of maximum if this service is provided by a paid provider: either agency or self-direction worker).
- Actual units authorized shall be based on Personal Care Assessment results and, to account for and avoid supplanting natural supports, can be no more than the number of units which equate to 50% of the units of Personal Assistance-Home that would otherwise be authorized if the person had no natural caregiver(s) or relative(s) in the home, providing these supports on an unpaid basis.
- Exception: If all natural caregivers or relatives living in the same residence with the person are disabled, infirmed, or age 65 or older, Personal Assistance-Home that is self-directed may be provided by ***both*** natural caregiver(s) or relative(s) living in the same residence with the person (who meet the above requirements) and a worker(s) employed through self-direction; however, in these situations, to account for and avoid supplanting natural supports, no more than 75% of the total units of Personal Assistance-Home that the individual is determined to need, based on the Personal Care Assessment, can be authorized. Of these paid units, no more than 25% may be provided by the natural caregiver(s) or relative(s) living in the same residence with the person.

- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit (for up to 90 days) as a cost-effective alternative to institutional placement, other medically necessary covered benefits, or transition to an enrollment group with a higher expenditure cap. Reauthorization for additional periods of time is possible with re-assessment and CSD and DDD central office approval.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Personal Assistance Worker		DDD Certified Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Assistance Worker	None	None	Minimum qualifications as defined in rule and/or policy.
DDD Certified Provider Agency	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

State:	
Effective Date	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Assistance Worker	ADMH DDD Certification	Annually
Certified Provider Agency	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Personal Assistance-Community**

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A range of services and supports designed to assist an individual with a disability to perform, participate fully in his/her community and supports for activities of daily living and instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability and that occur outside the home. Personal Assistance-Community services may be provided outside the person's home, at an integrated workplace where the person is paid a competitive wage, or other places in the broader community to support community participation, involvement and contribution by the person. Personal Assistance-Community services must be provided consistent with the goals/outcomes defined in the Person-

Centered Plan and with the over-arching goal of ensuring the individual's full community participation and inclusion.

Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Community provider in a manner that supports and enables the individual to achieve the highest level of independence possible. Personal Assistance-Community may be used to address assistance needs in the workplace and community, if personal care and assistance are the only type of supports an individual needs in these locations. Otherwise, personal care and assistance is included in Supported Employment or Community Integration Connections and Skills Training services and the provider of those services shall be responsible for these needs during the hours that Supported Employment on-the-job supports (i.e. Individual Job Coaching or Small Group supports) or Community Integration Connections and Skills Training services are provided.

Eligible Personal Assistance-Community services include the following:

- As appropriate to the individual need, based on the nature of the community involvement, this service includes assistance with instrumental activities of daily living outside the home, including accompaniment and minor problem-solving necessary to achieve and sustain increased independence, competitive integrated employment and inclusion in the community.
- Assistance to ensure the individual is always supported to the extent needed to interact with other members of the broader community, including assistance with engaging co-workers and community members participating in the same places and activities.
- Assisting individuals to develop an increased range of positive, reciprocal relationships is a key goal of Personal Assistance-Community.
- With consent of the individual, if natural supports and/or workplace colleagues are willing to provide supports that would otherwise be provided by a Personal Assistance-Community worker, this service involves training on how to provide the specific Personal Assistance services they are willing to provide.

As appropriate to the individual need, based on the nature of the community involvement, this service includes assistance, support, supervision and partial participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain competitive integrated employment, integrated community participation, involvement and contribution.

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

- Authorization based on individual need after accounting for the availability of sustainable natural supports. This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time.
- This service shall not supplant or duplicate Personal Care services available through the Alabama Medicaid State Plan for waiver enrollees under age 21.
- Not available to a waiver enrollee ages 5-20 during the hours public school is in session.

- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- This service cannot be delivered in a waiver participant's home or in a provider owned or controlled service setting of any kind.
- These services are available to a waiver participant receiving the Family Caregiver Preservation Stipend.
- This service is not available when another covered service is being provided and the assistance available through Personal Assistance-Community is a component part of this covered service. Support Coordinator monitors will review service delivery records to ensure that Personal Assistance is not delivered concurrent with Employment Supports, Breaks and Opportunities (Respite), Supported Living Services, Adult Family Home, or Community-Based Residential Services.
- Transportation of the person to and from this service is not included in the rate paid for this service. Where staff delivering this service meet a person at his/her home to start the service, transportation of the person *to* this service is not necessary and shall not be separately authorized. Likewise, where staff delivering this service on a given day conclude this service at the person's home, transportation of the person *from* this service is not necessary and shall not be separately authorized.
- Transportation for attending medical appointments is covered under Non-Emergency Medical Transportation and not included in this service.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit (for up to 90 days) as a cost-effective alternative to institutional placement, other medically necessary covered benefits, or transition to an enrollment group with a higher expenditure cap. Reauthorization for additional periods of time is possible with re-assessment and CSD and DDD central office approval.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐	Legal Guardian

State:	
Effective Date	

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Personal Assistance Worker		DDD Certified Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Assistance Worker	None	None	Minimum qualifications as defined in rule and/or policy.
DDD Certified Provider Agency	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Assistance Worker	ADMH DDD Certification	Annually
Certified Provider Agency	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 nonmedical
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
Service Title:	**Community Transportation**

State:	
Effective Date	

Enrollment Group(s):

Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

Transportation services offered in order to enable an individual to access the broader community, including competitive integrated workplaces, opportunities for integrated community participation, involvement and contribution, and community services, resources and businesses consistent with the Person-Centered Plan. These services allow people to engage in typical day-to-day (non-medical) integrated community opportunities and activities such as going to and from paid, competitive, integrated employment, stores, bank, social opportunities with other members of the broader community, social events, clubs and associations, other community activities, and attending a worship service when public or other community-based transportation services or transportation provided by natural supports are not available. As part of the service, a natural or paid support-giver may accompany the person using Community Transportation, if the need for such supports are necessary and documented in the Person-Centered Plan.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time.
- Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide this assistance without charge, although the service allows for a flat per diem reimbursement in the event/on the occasion such cost-free transportation from natural supports are not available.
- The planning team must ensure the most cost-effective means of transportation is utilized, while still assuring provision of reliable transportation when a waiver participant needs this transportation to access non-medical opportunities in the community.
- If a stand-alone transportation service provider (e.g., not the agency(s) providing other Waiver services at the destination) is required to provide Community Transportation, due to documented unavailability of other more cost-effective and available transportation resources, they will be reimbursed on a one-way trip basis, taking into account the need for wheelchair accessibility and whether the service is utilized for employment or integrated community activities.
- Actual costs (based on a flat reimbursement per mile of travel) for travel via a stand-alone transportation service provider must be calculated prior to authorization of the service and must not exceed the established maximum set in policy by DMH/DDD.

State:	
Effective Date	

- This service can reimburse a waiver participant that is age 21 or older for the necessary, reasonable and documented costs of fuel, insurance and/or maintenance, to enable a waiver participant to drive him/herself for the purpose of accessing employment, authorized Waiver services, and integrated community activities as specified in their PCP. If the waiver participant holds a valid driver's license and owns their own vehicle, this is the most cost-effective way to meet the individual's need for community transportation.
- If this service is not self-directed, this service is limited to 250 miles per month, except if used for individualized competitive integrated employment in which case limited to actual miles to/from individualized competitive integrated employment plus 120 miles per month.
- If this service is self-directed, this service is authorized as a monthly budget amount. Only documented transportation costs incurred will be reimbursed by the FMSA. Carry-over of unused amounts is limited to 25% and can be carried over for up to three (3) months.
- This service is not available when another covered service is being provided and transportation to/from and/or during the service is a component part of this covered service. Support Coordinator monitoring will review provision of the service to ensure no duplication of transportation components of services provided.
- Transportation for attending medical appointments is covered under Non-Emergency Medical Transportation and not included in this service. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which shall not be supplanted and which includes transportation to medical appointments as well as emergency medical transportation.
- This service may not be used for transportation between the waiver participant's home and a provider owned or controlled residential or non-residential setting.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E			X	Provider managed
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person	X	Relative	X	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Transportation Provider		Transportation Company	
	Natural Supports			
	Waiver Recipient			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Transportation Provider	License/permit, as applicable, from the Alabama Public Service	Certificate to operate, as applicable, from the Alabama Public Service Commission	Individual transportation providers must comply with the Alabama Motor Carrier Act and must be certified or be issued a permit to operate, as applicable, by the

	Commission and any local authorities	and any local authorities	Alabama Public Service Commission. In addition, they must adhere to any local certification or licensure requirements.
Transportation Company	License/permit, as applicable, from the Alabama Public Service Commission and any local authorities	Certificate to operate, as applicable, from the Alabama Public Service Commission and any local authorities	Stand-alone transportation companies must comply with the Alabama Motor Carrier Act and must be certified or be issued a permit to operate, as applicable, by the Alabama Public Service Commission. In addition, they must adhere to any local certification or licensure requirements.
Natural Supports	Valid Alabama Driver's License		
Waiver Recipient	Valid Alabama Driver's License		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Transportation Provider	ADMH DDD Certification	Annually
Transportation Company	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of- home
Category 2:	Sub-Category 2:
09 Caregiver Support	09012 respite, in home
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
Service Title:	**Breaks and Opportunities (Respite)**

State:	
Effective Date	

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:
A service provided to a waiver participant that lives with family or other natural supports who are providing support, care and supervision to the waiver participant. The Breaks and Opportunities service is provided for time-limited periods when the family or other natural supports are temporarily unable to continue to provide support, care and supervision to the waiver participant. This service can be provided in the waiver participant's home or the pre-approved private home of the Breaks and Opportunities service provider. The Breaks and Opportunities service is provided with two equally important goals which include: (1) sustaining the family/natural support living arrangement and support-giving arrangement; and (2) providing the waiver participant with opportunities to continue his/her regular activities and relationships and/or to explore new opportunities and meet new people with the Breaks and Opportunities service provider.

This service is provided during specific periods of time in a day, week or month when the unpaid family/natural support-givers typically provide support, care and supervision to the waiver participant. This service is provided in a way that ensures the individual's typical routine and activities are not disrupted and the individual's goals and needs, as set forth in the PCP, are attended to without disruption.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- This service shall be limited to 30 days of service per person per calendar year or to 216 hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the Person-Centered Plan. (The 2 limits cannot be combined in a calendar year.)
- This service shall be provided in non-institutional settings that meet the federal HCBS regulatory standards and which promote community involvement and inclusion. Breaks and Opportunities may not be provided in a group home of more than four (4) beds. Group homes are considered the most restrictive, least integrated setting option for this service.
- This service may be authorized to cover specific periods of time when a primary caregiver who is receiving the Family Caregiver Preservation Stipend is temporarily unable to continue to provide support, care and supervision to the waiver participant.
- This service is typically scheduled in advance, but it can also be provided in an unexpected situation. If the unexpected situation is a crisis, this service is used to allow time and opportunity for assessment, planning and intervention in order to prevent the loss of the family/natural support living arrangement and support-giving arrangement as the first priority. If all efforts and strategies to sustain the family/natural support living arrangement and support-giving arrangement have been exhausted and have proven unsuccessful, this service can be used to identify and establish an alternative living arrangement for the waiver participant, focusing on the least restrictive, most integrated living arrangement possible while ensuring institutionalization can be avoided.
- The relief needs of paid direct support staff, including staff hired through self-direction, who are not family or natural support-givers will be accommodated by staffing substitutions and/or service delivery schedule adjustments; but not by this service.

State:	
Effective Date	

- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit, if the benefit limit has been exhausted in a waiver year, as a cost-effective alternative to other medically necessary covered benefits, transition to an enrollment group with a higher expenditure cap, or to avoid institutional placement.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Respite Worker		DDD Certified Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Respite Worker	None	None	Minimum qualifications as defined in rule and/or policy.
DDD Certified Provider Agency	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Worker	ADMH DDD Certification	Annually
Certified Provider Agency	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system

State:	
Effective Date	

Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Remote Supports**

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
The provision of supports to a waiver participant at their place of residence by Remote Support staff housed at a remote location and who are engaged with the person through equipment with the capability for live, two-way communication. Remote Supports shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using the appropriate stable, reliable connection.

While Remote Supports are being provided, the remote support staff shall not have duties other than remote support. Equipment used to meet this requirement may include but is not limited to one or more of the following components:

- Sensor Based System (e.g. motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.)
- Radio frequency identification;
- Live video feed;
- Live audio feed;
- Web-based monitoring system;
- Another device that facilitates live two-way communication;
- Contact ID

Remote Supports are provided pursuant to the Person-Centered Plan (PCP) and required protocol(s) that are developed from, and support implementation of, the PCP. Remote Supports are intended to address a person's assessed needs in his/her residence, and are to be provided in a manner that promotes autonomy and minimizes dependence on paid support staff. Remote Supports should be explored prior to authorizing services that may be more intrusive, including Personal Assistance-Home. A person's team, including the person themselves, shall assess whether Remote Support is appropriate and sufficient to ensure the person's health and welfare assuming all appropriate protocols are in place to minimize risk as compared to the overall benefit of Remote Supports for the individual.

A backup support person is always identified, available and responsible for responding to the site of the person's residence whenever the person otherwise needs in-person assistance, including emergencies. Backup support may be provided on an unpaid basis by a family member, neighbor, friend, or other person selected by the individual, or on a paid basis by a local provider of waiver services. When backup support is provided on a paid basis by a local provider, that provider shall be the primary contact for the Remote Support vendor.

The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the backup support person(s) to provide assistance when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off. When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP, but no longer than one (1) hour) when a request for in-person assistance is made.

If a known or reported emergency involving a person arises, the Remote Support staff shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the backup support person. The Remote Support staff shall stay engaged with the person during an emergency, as appropriate to the situation, until emergency personnel or the backup support person arrives.

The Remote Supports vendor shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring base system and have training on the most recent versions of the written protocols for each person supported. The Remote Supports vendor shall ensure a suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP.

The Remote Supports vendor shall have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages. The Remote Supports vendor shall have other backup systems and additional safeguards in place which shall include, but are not limited to, contacting the backup support person in the event the monitoring base system stops working for any reason. The Remote Supports vendor shall comply with all federal, state, and local regulations that apply to the operation of its business or trade, including but not limited to, 18 U.S.C. section 2510 to section 2522 as in effect on the effective date of this rule. The Remote Supports vendor shall have an effective system for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- Remote Supports shall only be provided in waiver participants' places of residence when paid or unpaid sources of support are not present in the residence, except temporarily, if needed, when the Remote Supports are being initially introduced. In Supported Living or Community-Based Residential settings, the reimbursement rate to the provider shall be adjusted to account for the use of Remote Supports and the provider's role in providing backup support for the waiver participant(s) in the residence.
- Camera systems are located in communal areas of the home where the individual is likely to spend time and not places where an individual may wish to go to gain privacy (e.g., bathroom or bedroom). Systems are customizable and can be located wherever the individual prefers.
- When Remote Supports involve the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the person who receives the service and each person who lives with the person shall consent in writing after being fully informed of

what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person or a person who lives with the person has a guardian, the guardian shall consent in writing. The person's service and support administrator shall keep a copy of each signed consent form with the PCP.

- A monitoring base shall not be located at the residence of a person who receives Remote Supports.
- A secure network system requiring authentication, authorization, and encryption of data that complies with applicable state laws currently in effect shall be in place to ensure that access to computer, video, audio, sensor, and written information is limited to authorized persons.
- If a Reportable Event as defined in the DDD Critical Incident Prevention and Management System occurs while a person is being monitored, the Remote Supports provider shall retain, or ensure the retention of, any video and/ or audio recordings and any sensor and written information pertaining to the incident for at least seven years from the date of the incident.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize use of this service in the home of a waiver participant(s) living with family as a cost-effective alternative to other medically necessary covered benefits, transition to an enrollment group with a higher expenditure cap, or to avoid institutional placement. Reauthorization is possible with re-assessment and CSD and DDD central office approval.
- All residents of a home where Remote Supports are provided must give advance, informed consent to being subject to the remote monitoring apparatus, as must anyone who later joins the residence. In addition, there must be a protocol (e.g., a written sign, etc.) for informing visitors to the residence that they might be recorded.
- When a person receives Remote Supports with paid backup support, the Remote Supports provider shall bill for the Remote Supports and provide the remote support directly or through a contract with a Remote Supports vendor that meets the requirements of this rule. In the event that the remote support staff contact the Remote Supports provider to request emergency or in-person assistance, the paid backup support person's time shall be billed as Personal Assistance or Self-Directed Personal Assistance, as applicable.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E		X	Provider managed		
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person	X	Relative	X	Legal Guardian	

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Back-Up Support Worker		Paid Back-Up Support Provider	
			Technology Installer & Provider	

Provider Qualifications

State:	
Effective Date	

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Back-Up Support Worker	None	None	Minimum qualifications as defined in rule and/or policy.
Paid Back-Up Support Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.
Technology Installer & Provider	As applicable to federal, state and local statutes	As applicable to federal, state and local statutes	Recognized and experienced vendor or Remote Supports technology with experience in at least two (2) other states and current capability to provide Remote Supports services in geographic areas covered by this waiver in State of Alabama.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Back-Up Support Worker	ADMH DDD Certification	Annually
Paid Back-Up Support Provider	ADMH DDD Certification	Annually
Technology Installer & Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
Service Title:	**Assistive Technology and Adaptive Aids**
Enrollment Group(s):	Essential Family Preservation Supports Seamless Transition to Adulthood Supports

State:	
Effective Date	

Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in their home, in community participation, and in competitive integrated employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform activities of daily living or instrumental activities of daily living independently or more cost effectively than would be possible otherwise. This service must include strategies for training the individual, natural/unpaid and paid supporters of the individual in the setting(s) where the technology and/or aids will be used, as identified in the Person-Centered Plan (PCP).

Assistive Technology and Adaptive Aids covers the following:

- Evaluation and assessment of the Assistive Technology and Adaptive Aids needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments where the person is expected to use the specific technology or equipment, including the home, integrated employment setting(s) and integrated community locations;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;
- Adaptive equipment to enable the individual to complete activities of daily living or instrumental activities of daily living independently or to do so in a way that either allows natural supports to provide the human assistance still needed or allows the cost of paid supports otherwise needed to be reduced to offset the cost of the technology or aid within one (1) year. Such assistive technology or adaptive equipment includes:
    - Adaptive switches and attachments;
    - Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes);
    - Adaptive toileting equipment;
    - Communication devices and aids that enable the person to perceive, control or communicate with the environment, including a variety of devices for augmentative communication;
    - Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume

State:	
Effective Date	

control telephones, large print telephones and teletouch systems, and long white canes with appropriate tips to identify footpath information for people with visual impairment);

- Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace (unless eligible as a reasonable accommodation by the employer) and in the community;
- Software, when required to operate accessories included for environmental control;
- Pre-paid, pre-programmed cellular phones that allow an individual, who is participating in employment or community integration activities without paid or natural supports and who may need assistance from remote sources of support or due to an accident, injury or inability to find the way home, to access such assistance independently. The person's PCP outlines the protocol that is followed for training, regular practice in using and regular checks of operability for a cellular phone including plan for when the individual may have an urgent need to request help while in the community;
- Such other durable and non-durable medical equipment not available under the state Medicaid plan that is necessary to address functional limitations in the community, in the workplace, and in the home.

- Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the Assistive Technology and Adaptive Aids.
- Coordination and use of necessary therapies, interventions, or services with assistive technologies and adaptive aids, such as therapies, interventions, or other services in the PCP.
- Repairs of equipment and items purchased through this Waiver or purchased prior to Waiver participation, as long as the item is identified within this service definition, and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- Items reimbursed with waiver funds shall be non-duplicative of, and to meet an assessed need(s) in addition to, any medical equipment and supplies available to the individual and furnished under the state Medicaid plan. Repairs of items purchased under the state Medicaid plan shall be covered by the state Medicaid plan.
- Items reimbursed with waiver funds shall exclude those items which are not of direct medical or remedial benefit to the recipient.
- All items must meet applicable standards of manufacture, design and installation.

State:	
Effective Date	

- A written recommendation by an appropriate professional (most typically, the professional that completed the evaluation and assessment or a prescription from a physician) must be obtained to ensure that the equipment will meet the needs of the person. For Assistive Technology and Adaptive Aids in the workplace, the recommendation of the Alabama Department of Rehabilitative Services/Vocational Rehabilitation (ADRS/VR) can also meet the requirement of a written, professional recommendation.
- The provision of this service to support the person in competitive integrated employment is only available for an individual who is working in competitive integrated employment and only if what is needed is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Persons interested in obtaining competitive integrated employment should be referred to ADRS/VR, and the need for assistive technology and/or adaptive aids will assessed and identified in the ADRS/VR process.
- Depending upon the financial size of the employer or the employer's status as a public entity, these employers may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Authorized Equipment Vendor

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Authorized Equipment Vendor	Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.		

State:	
Effective Date	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Authorized Equipment Vendor	DDD Fiscal Management	Upon selection

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
03 Supported Employment	03010 job
Category 2:	Sub-Category 2:
03 Supported Employment	03021 ongoing supported
Category 3:	Sub-Category 3:
03 Supported Employment	03030 career planning
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Employment Supports – Individual Employment Support**

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

A progression of services provided, as needed, on an individual basis for a person who, because of their disability(s), needs support in order to obtain and/or maintain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. These services are designed to support the achievement of individualized integrated employment outcomes consistent with the person's employment/career goals and conditions for success, as determined through Exploration and/or Discovery if such services are needed to accurately identify these goals and conditions.

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The expected outcome of this service is sustained paid employment in a competitive or customized job, with an employer who is not the person's service provider, and for which a person is compensated at or above the minimum wage, but not less than the customary wage paid by the employer for the same or similar work performed by persons without disabilities. The job also offers the level of benefits offered by the employer to persons without disabilities performing the same or similar work.

Supported Employment—Individual Employment Support services are individualized and may include the following components:

Exploration

A time-limited and targeted service designed to help a person make an informed choice about whether they wish to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. Exploration shall be limited to no more than thirty (30) calendar days from the date of service initiation. This service is not appropriate for persons who know they want to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. The service includes introductory activities to identify a person's areas of specific interest, experience and skill related to individualized, integrated employment.

This service also includes exploration of employment opportunities that are specifically related to the person's identified interests, experiences and/or skills through at least three uniquely arranged business tours, informational interviews and/or job shadows. Each activity shall include time for set-up, prepping the person for participation in the activity, and debriefing with the person after each opportunity.

This service also includes introductory, basic education on the numerous work incentives for SSI and/or SSDI beneficiaries and how Supported Employment services work (including Vocational Rehabilitation services). The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report, on a template issued by DMH/DDD, summarizing the process and outcomes, due no later than forty-five (45) calendar days after the service commences. Exploration is paid on an outcome basis, after the written report is received and approved.

Discovery

A time-limited and targeted service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, designed to help a person, who wishes to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage, to identify through person-centered assessment, planning and exploration:

- Strong interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers;
- Conditions necessary for successful employment.

Discovery may involve a comprehensive analysis of the person's history, interviews with family, friends and

support staff, observing the person performing work skills, and career research in order to determine the person's career interests, talents, skills and support needs, and the writing of a Profile, a pre-assessment specific to the needs of Waiver-eligible persons, which may be paid for through the Waiver in order to provide a valid assessment for Vocational Rehabilitation (VR) services to begin, which would begin with the development of an Employment Plan through ADRS.

Discovery shall be limited to no more than sixty (60) calendar days from the date of service initiation. The provider shall document each date of service, the activities performed that day, and the duration of each activity. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized, integrated employment. Discovery results in the production of a detailed written Profile, following content requirements established by DMH/DDD, summarizing the process, learning and recommendations for next steps. The written Profile is due no later than seventy-five calendar (75) days after the service commences. Discovery is paid on an outcome basis, after the written Profile is received and approved.

Job Development Plan

A time-limited and targeted service, if otherwise not available to the individual from the Alabama Department of Rehabilitative Services, designed to create a clear plan for Job Development to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is limited to thirty (30) calendar days from the date of service initiation. This service includes a planning meeting involving the person and other key people who will be instrumental in supporting the person to become employed in an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service may also include assistance with the submission of a PASS Plan to the Social Security Administration, depending on the needs of the individual. This service culminates in a written plan, on a template issued by DMH/DDD, directly tied to the results of Exploration, Discovery, as applicable when previously authorized, and is due no later than thirty (30) calendar days after the service commences.

Job Development

Job Development is a service, if otherwise not available to the individual from the Alabama Department of Rehabilitative Services, that supports a person to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is designed to implement the Job Development Plan, if applicable, and should result in the achievement of an individualized, integrated employment outcome consistent with the person's employment and career goals, as determined through Exploration (if necessary), Discovery (if necessary) and/or the employment planning process and reflected in the PCP.
The Job Development strategy should reflect best practices and whether the person is seeking competitive or customized employment. This service will be paid on an outcome basis once an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the

minimum wage has commenced, with payment tiered based upon the person's level of disability (ICAP score; additional assessment as identified by DMH/DDD).

Job Coaching

Job Coaching for individualized, integrated employment, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, includes identifying and providing services and supports that assist the person in maintaining and advancing in individualized employment in an integrated setting. Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face. Job Coaching supports must be guided by a Job Coaching fading plan and must include systematic instruction utilizing task analysis to teach the person to independently complete as much of their job duties as possible.

Examples of Job Coaching strategies that may be approved include:

- Job analysis
- Job adaptations
- Instructional prompts
- Verbal instruction
- Self-management tools
- Physical assistance
- Role play
- Co-worker modeling
- Written instruction

Assistive Technology should also be introduced whenever possible to increase independence and productivity. Job Coaching also must include the engagement of natural supports (e.g., employers, supervisors, co-workers, or volunteers at the job site; or friends or family members in supportive roles) in the workplace to provide additional targeted supports that allow the job coach to maximize his/her ability to fade.

Job Coaching is not time-limited. The amount of time authorized for this service is a percentage of the person's hours worked, based on individual need. Payment per unit of service is tiered to encourage fading and is also based on the person's level of disability ((ICAP score; DMH/DDD functional assessment) and the length of time the person has been employed.

This service cannot include payment for the supervisory and co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The use of this service shall be authorized on a time limited basis (i.e., no more than 180 days) and reviewed to determine amount of service needed during next authorization period.

Career Advancement

A time-limited career planning and advancement support service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, for persons currently engaged in individualized, integrated employment who wish to obtain a promotion and/or a second individualized, integrated employment opportunity. The service focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized, integrated employment or self-employment opportunity.

The outcomes of this service are:

- The identification of the person's specific career advancement objective;
- Development of a viable plan to achieve this objective; and
- Implementation of the plan which results in the person successfully achieving his/her specific career advancement objective.

Career Advancement is paid on an outcome basis, after key milestones are accomplished:

- Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. The written plan must follow the template prescribed by DMH/DDD.
- Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of forty (40) hours.

This service may not be included on a PCP if the PCP also includes any of the services that are also covered under Supported Employment-Individual Employment Support, except Job Coaching. This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), and if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference(s), performance review(s) and/or good attendance record from current employer). The only exception is in situations where the provider who was previously authorized and paid for outcome payment number one did not also earn outcome payment number two because they did not successfully obtain a promotion or second job for the person. In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

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

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- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The Supported Employment—Individual Employment Support provider shall be responsible for any Personal Assistance needs during the hours that Supported Employment services are provided. However, the Personal Assistance services may not comprise the entirety of the Supported Employment—Individual Employment Support service. All providers of Personal Assistance under Supported Employment—Individual Employment Support shall meet the Personal Assistance provider qualifications.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- Transportation of the person to and from this service is not included in the rate paid for this service. Where staff delivering this service meet a person at his/her home to start the service, transportation of the person *to* this service is not necessary and shall not be separately authorized. Likewise, where staff delivering this service on a given day conclude this service at the person's home, transportation of the person *from* this service is not necessary and shall not be separately authorized.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
- If a person is successfully employed in individualized, integrated employment, services may be used to explore advancement opportunities in his or her chosen career, if such services are not otherwise available to the individual through Alabama Division of Rehabilitation Services.

- Social Security's Ticket to Work Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since Ticket to Work payments are made for an outcome, rather than for a Medicaid service rendered.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
    - Payments that are passed through to users of supported employment services; or
    - Payments for training that is not directly related to a person's supported employment program.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Job Developer		DDD Certified Provider Agency	
	Job Coach			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Job Developer	None.	See Other.	Minimum qualifications as defined in rule and/or policy. For Exploration, Discovery, Job Development Plan, Job Development and Career Advancement, DSPs must qualify as a Job Developer. To do this, DSPs shall also meet the following qualifications: completion of a minimum of one certificate-based Job Development and Placement curriculum.
Job Coach	None.	See Other.	Minimum qualifications as defined in rule and/or policy. For Job Coaching and Co-Worker Supports, DSPs must qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network *Job Coaching and Consulting* course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).

DDD Certified Provider Agency	None.	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy. Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Job Developer	ADMH DDD Certification	Annually
Job Coach	ADMH DDD Certification	Annually
DDD Certified Provider Agency	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
Service Title: **Employment Supports – Small Group Supports** Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up) Family, Career and Community Life Supports Supports to Sustain Community Living	

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Definition:
A service providing employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. The service may include:

- Small group career planning and Exploration
- Small group Discovery classes/activities
- Other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment
- Employment in integrated business, industry and community settings

Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time.

The maximum group size for mobile crews and enclaves is four (4) people with disabilities working together while receiving this service.
In the enclave model, a small group of people with disabilities (no more than four (4) people) is trained and supervised to work as a team among employees who are not disabled at the host company's work site.

In the mobile work crew model, a small crew of workers (including no more than four (4) persons with disabilities and ideally also including workers without disabilities who are not paid providers of this service) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community.

In each model, the Supported Employment—Small Group Supports provider is responsible for training, supervision, and support of participants.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals, as documented in their PCP. Supported Employment—Small Group Supports shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment.

Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the PCP must document that such opportunities are being provided through this service, to the person, on an on-going basis. The PCP shall also document and address any barriers to the person transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any person using this service to

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supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

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

- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings. The settings must be integrated in and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment, engage in community life, and control their earned income.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- Paid work under Supported Employment—Small Group Supports must be compensated at minimum wage or higher.
- Supported Employment—Small Group Supports does not include vocational or Employment Path services, employment or training provided in facility-based work settings.
- Transportation of the person to and from this service is not included in the rate paid for this service; however transportation provided during the course of Supported Employment—Small Group Supports is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.
- This service will not duplicate other services provided through Medicaid state Waiver plan services or through 1915(i) state plan services and may not be billed for during the same period of time (e.g., the same hour) as other such services.
- The Supported Employment—Small Group Supports provider shall be responsible for any Personal Assistance needs during the hours that Supported Employment-Small Group Supports are provided; however, the Personal Assistance services may not comprise the entirety of the Supported Employment—Small Group Supports service. All providers of Personal Assistance under Supported Employment—Small Group Supports shall meet the Personal Assistance service provider qualifications, as verified during initial provider certification and follow-up certification surveys.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- This service does not include support for volunteering.
- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized,

documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). A person does not have to be found ineligible for services under section 110 of the Rehabilitation Act of 1973 to determine and document this service is not available.

- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
  - Payments that are passed through to users of supported employment services; or
  - Payments for training that is not directly related to a person's supported employment program.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Job Coach		DDD Certified Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Job Coach	None.	See Other.	Minimum qualifications as defined in rule and/or policy. For Job Coaching and Co-Worker Supports, DSPs must qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network *Job Coaching and Consulting* course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).
DDD Certified Provider Agency	None.	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy. Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing

			Supported Employment or similar employment services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Job Coach	ADMH DDD Certification	Annually
DDD Certified Provider Agency	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
03022 ongoing supported	03021 ongoing supported
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: Co-Worker Supports

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
This service involves the provider of this service (who receives a monthly service fee for their ongoing oversight and involvement) entering into an agreement with the employer to reimburse the employer who will in turn reimburse one or more co-workers and/or supervisors, agreeable to the person supported, for supports in lieu of a Job Coach.

This service can be considered at any time the individual wishes to have Co-Worker Supports rather than

Job Coaching, given that Co-Worker Supports are less intrusive and expected to be less costly to implement than Job Coaching. This service can be used when an employer wants to hire an individual; but has reasons for not wanting an external job coach in the workplace. This service must be considered as an option with the individual and his/her employer if fading of Job Coaching has ceased to continue for at least six (6) months. The use of this service should also be authorized on a time limited basis (i.e., no more than 180 days) and reviewed to determine need for renewal/continuation. This service cannot include payment for the supervisory and co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The co-worker(s) and/or supervisor(s) identified to provide the support to the person must meet the minimum qualifications (e.g., training, background checks, etc.) for a legally responsible individual as provider of this service. The provider is responsible for oversight and monitoring of paid Co-Worker Supports.

The actual amount of Co-Worker Supports authorized is based on individual need as determined through an on-the-job support assessment the format for which is prescribed by DMH/DDD and as outlined in a Co-Worker Supports Agreement using a template prescribed by DMH/DDD and jointly signed by the person, the provider and the employer.

The provider must ensure the following as part of utilizing Co-Worker Supports:

- A formal written agreement is in place outlining the nature and amount of the supports, above and beyond natural supports, to be provided to the member by the employer, the amount of time necessary for the supervisor(s) or co-worker(s) to provide this support and the cost to the employer for this support, which will be reimbursed by the provider. The agreement should include expectations regarding documentation and billing necessary for the employer to be reimbursed by the provider.
- The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must pass background checks otherwise required for Job Coach. The provider is responsible for ensuring these checks are done (by the employer or provider) and for retaining copies of background check results on file.
- Providing an orientation training to the supervisor(s) and/or co-worker(s) identified to provide the support to the individual which includes the following content:
    - Basic introduction to Supported Employment
    - Explanation of the Co-Worker Supports model of support – what is covered/not covered; expected outcomes
    - Overview of best practices for coaching to promote maximum independence and performance
    - Training specific to the member, including support plan, communication style, learning style, support needs and specific needed related to performing and maintaining his/her job that the supervisor(s) or co-worker (s) is expected to address;
    - Role and availability of the provider in supporting the member, the employer/supervisor, and co-worker(s) providing support to the member;
    - Contact information for the provider, including emergency/back-up cell phone numbers;
    - Documentation requirements necessary for the provider to invoice Medicaid and make payment to the employer based on the supports provided to the member.

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- The provider is available to provide back-up supports and/or additional training/technical assistance for the employer and member whenever this may be needed;
- The provider completes minimum monthly check-ins with the employer and the member.

Based on all of the above expectations, the provider maintains records of each Co-Worker Supports arrangement for review by DMH/DDD at any time or as a part of annual certification. Records should include, at minimum: current written agreement between the employer and provider as described above; valid copies of background checks; proof of completion of training for supervisor(s) and co-worker(s) providing supports to the member; evidence of monthly check-ins being completed; billing documentation submitted by the employer to support payments to the employer; record of reimbursements made to the employer and tax documents issued to the employer (e.g. 1099 forms) by the provider.

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

- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The Supported Employment provider overseeing the Co-Worker Supports arrangement shall be responsible for any Personal Assistance needs not met by Co-Worker Supports and shall bill this time as Job Coaching. All providers of Personal Assistance under Supported Employment—Individual Employment Support shall meet the Personal Assistance provider qualifications.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.

- Social Security's Ticket to Work Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since Ticket to Work payments are made for an outcome, rather than for a Medicaid service rendered.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
    - Payments that are passed through to users of supported employment services; or
    - Payments for training that is not directly related to a person's supported employment program.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
		Co-Worker Supports Worker		DDD Certified Provider
		Co-Worker Supports Supervisor		

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Co-Worker Supports Worker	None	None	Minimum qualifications as defined in rule and/or policy.
Co-Worker Supports Supervisor	None	None	Minimum qualifications as defined in rule and/or policy.
DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy. Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Co-Worker Supports Worker	ADMH DDD Certification	Annually
Co-Worker Supports Supervisor	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
03 Supported Employment	03010 job
Category 2:	Sub-Category 2:
04 Day Services	04010 prevocational
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: Integrated Employment Path Services

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.
Persons receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCP as the goal that Integrated Employment Path Services are specifically authorized to address.

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Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's specific individualized integrated employment and/or self-employment goals and career goals. If such specific goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment, including (but not limited to):

- Ability to communicate effectively with supervisors, co-workers and customers;
- Generally accepted community workplace conduct and dress;
- Ability to follow directions;
- Ability to attend to tasks;
- Workplace problem solving skills and strategies; and
- General workplace safety and mobility training.

This service is limited to no more than one year. One extension of up to one year can be allowed only if the person is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e. ADRS Individualized Plan for Employment in place or Job Development or Self-Employment Start-Up funded by the Waiver) is concurrently authorized for this purpose. The one-year extension may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.

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

- Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for individualized integrated employment or self-employment), Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.
- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service will not duplicate other services provided through Medicaid state Waiver plan services and may not be billed for during the same period of time (e.g., the same hour) as other such services.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week. Expenditure caps also apply. Depending on enrollment group and age, the services the person is

eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.

- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Job Coach		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Job Coach	None.	See Other.	Minimum qualifications as defined in rule and/or policy. For Job Coaching and Co-Worker Supports, DSPs must qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network *Job Coaching and Consulting* course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).
DDD Certified Provider Agency	None.	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy. Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Job Coach	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community
Category 2:	Sub-Category 2:
04 Day Services	04070 community integration
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	

Service Title: **Community Integration Connections and Skills Training**

Enrollment Group(s): Family, Career and Community Life Supports
Supports to Sustain Community Living (adults age 22+)

Definition:
Time-limited services which identify and arrange integrated opportunities for the person to achieve his/her unique goals for community participation, involvement, membership, contribution and connections, including targeted education and training for specific skill development to enable the waiver participant to develop ability to independently (or with natural supports only) engage in these integrated opportunities as specified in the person's Person-Centered Plan.

This service focuses specifically on successful participation in community opportunities that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service also focuses on ensuring the ongoing interactions with members of the broader community are meaningful and positive, leading to the development of a broader network of natural supports for the individual.

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The community connections component of this service is focused on assisting the person to find and become engaged in specific opportunities for community participation, involvement, membership, contribution and connections. The service focus on community connections includes the following:

- Connections to members of the broader community who share like interests and/or goals for community participation, involvement, membership and/or contribution.
- Connections to community organizations and clubs to increase the individual's opportunity to expand community involvement and relationships consistent with his/her unique goals for community involvement and expanded natural support networks, as documented in the Person-Centered Plan;
- Connections to formal/informal community associations and/or neighborhood groups;
- Community classes or other learning opportunities related to developing passions, interests, hobbies and further mastery of existing knowledge/skills related to these passions, interests and hobbies;
- Connections to community members, opportunities and venues that support an individual's goals related to personal health and wellness (e.g. yoga class, walking group, etc.);
- Connections to volunteer opportunities focused primarily on community contribution rather than preparation for employment;

The provider must document weekly progress toward achieving each goal for community participation, involvement, membership, contribution and connections for which the service is specifically authorized and which is documented in the Person-Centered Plan.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve their personally identified goals for community participation, involvement, membership, contribution and connections, including developing and sustaining a network of positive natural supports. The provider is expected to provide this service in the appropriate integrated community setting(s) where the opportunities take place and the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

The skills training component of this service is instructional and training-oriented, and not intended to provide substitute task performance by staff. Skill training is focused on the development of skills identified in the Person-Centered Plan that will enable the person to continue participation in integrated community opportunities without waiver-funded supports.

Community Integration Connections and Skills Training may include only education and training for skill development related to:

- Developing and maintaining positive reciprocal relationships with members of the broader community who are not other waiver participants, paid staff or family members;
- Participation in community activities, clubs, formal or informal membership groups and other opportunities for community involvement, participation and contribution (all so long as the activity clearly meets a goal(s) designated in the PCP);
- Accessing and using community services and resources available to the general public;

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- Safeguarding personal financial resources in the community;
- Mobility training and travel training;
- Cell phone and/or PERS use in the community;
- Skills for personal safety in the community.

The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant. The provider must document weekly progress toward achieving each goal for community integration skill development and independence identified in the Person-Centered Plan.
The Community Integration Connections and Skills Training provider shall be responsible for any Personal Assistance needs during the hours that Community Integration Connections and Skills Training services are provided. However, the Personal Assistance services may not comprise the entirety of the Community Integration Connections and Skills Training.

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

- All settings where Community Integration Connections and Skills Training is provided must meet all HCBS Settings Rule standards and cannot be provider owned or controlled.
- The service amount, duration, and scope must be documented in the PCP.
- This service is provided separate and apart from the person's private (including family) residence, other residential living arrangement and/or the home of a service provider and is not provided in provider owned or controlled facilities.
- One expected result of this service is fading of the service and less dependence on paid support over time in favor of increased natural supports and skills for community involvement and participation;
- This service can be authorized on a time-limited basis to facilitate one or more community connections and/or to facilitate acquisition or mastery of one or more skills for participation in integrated community opportunities and relationships.
- This service is intended to be a "wrap-around" support to participation in individualized, competitive integrated employment, Supported Employment-Small Group services and/or Integrated Employment Path Services, or is intended for individuals of retirement age (65+) who have elected not to pursue further employment opportunities, or for individuals who, after participating in the informed choice process available through completion of the Exploration service, have decided not to pursue individualized, competitive integrated employment at this time.
- Staff-to-person ratios may vary from 1:1 to 1:3, with variable payment based on the specific ratio.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or

more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services.

- The specific hours per week allowable to a person, and their associated employment status, will be documented in the PCP and will be verified during Support Coordinator monitoring of the service's delivery.
- Expenditure caps also apply.
- Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Community Integration Worker		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Integration Worker	None	None	Minimum qualifications as defined in rule and/or policy. Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities. Must hold at least a associate's degree from an accredited institution in a human services field. Must complete a training course on training methods provided by DDD.
DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Community Integration Worker	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08010 homebased habilitation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	

Service Title: **Independent Living Skills Training**

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

Time-limited, focused service that provides targeted education and training for specific skill development to enable the waiver participant to develop ability to independently perform routine daily activities at home as specified in the person's Person-Centered Plan. Services are not intended to provide substitute task performance by staff. Services are instructional and training-oriented, focused on development of skills identified in the Person-Centered Plan. Independent Living Skills Training may include only education and training for skill development related to:

- Personal hygiene, self-care skills and routines
- Food and meal preparation, including menu planning
- Home upkeep/maintenance including outdoor upkeep/maintenance as applicable
- Money management including skills for controlling and safeguarding personal financial resources at home
- Home-based communication device use (e.g. computer/phone/cell phone)

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- Skills for personal safety at home
- Parenting skills (if minor children of waiver participant residing with waiver participant)

Independent Living Skills Training is intended as a short-term service designed to allow a person to acquire specific skills for independence in defined tasks and activities for community living.
Goals for skill development and independence at home must be age-appropriate for the waiver participant while recognizing that learning skills for maximizing individual initiative, autonomy and independence at home should start at a very young age. The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant.

Because home-based skills are being taught, parents and/or other natural supports in the home will be encouraged to observe the training so they can learn how to use the instructional strategies, reinforce the learned skills and contribute to ensuring the maintenance of these skills after the service ends.

The provider must document weekly progress toward achieving each independent living skill identified in the Person-Centered Plan. The provider is expected to provide this service in the person's own home where the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

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

- The service amount, duration, and scope must be documented in the PCP.
- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- This service may be authorized for a maximum of 10 hours/week (no more than 2 hours/day) but shall be appropriate to the goal for authorizing the service and the person's existing level of skill (gap between existing level of skill and goal) prior to the service being authorized;
- Once a waiver participant has achieved the ability to independently perform specific routine daily activities, this service may only be authorized to address a *different* routine daily activity (e.g., the above service limitations are enforced per skill identified as in need of training as specified in the person's PCP), or authorized, if needed, only very intermittently and for minimal time, to focus on sustaining skills for independence already achieved so these are not lost.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐ Legal Guardian

Provider Specifications

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Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Independent Living Skills Trainer		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Independent Living Skills Trainer	None	None	Minimum qualifications as defined in rule and/or policy. Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities. Must hold at least a associate's degree from an accredited institution in a human services field. Must complete a training course on training methods provided by DDD.
DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Independent Living Skills Trainer	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self
Category 3:	Sub-Category 3:

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Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Peer Specialist Services**

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A service that assists a person to develop and utilize skills and knowledge for self-determination in one or more of the following areas:

- Directing the person-centered planning (PCP) process;
- Understanding and considering self-direction;
- Understanding and considering individualized integrated employment/self-employment; ands
- Understanding and considering independent and supported living community living options.

The service is provided on a time-limited basis, determined by the person's individual need, by a peer with intellectual or developmental disabilities who has experience matched to the focus areas, needs and goals of the person receiving this service: has successfully directed their own Person-Centered Planning process; has self-directed their own services; has successfully obtained individualized integrated employment at a competitive wage; and/or utilizes independent/supported living options.

A qualified Peer Specialist service provider understands, empathizes with the person while working to empower the person, supporting three critical areas important for enhancing self-esteem and self-determination:

- The human need for connections, social supports and allies;
- Overcoming the disabling power of learned helplessness, low expectations, and the stigma of labels; and
- Supporting self-advocacy, informed choice and dignity of risk in decision making.

The Peer Specialist service provider offers:

- Education and training on the principles of self-determination, informed decision making and informed risk-taking;
- One-on-one training, information and targeted support to encourage and support the person to lead their own Person-Centered Planning process, pursue self-direction, seek individualized, integrated competitive employment and/or pursue independent living/supported living options in the community;
- Education on self-direction, including best practices recruiting, hiring and supervising staff;
- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing individualized, integrated competitive employment;

- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing independent/supported living opportunities, including selection of place to live and, if needed or desired, housemates; and,
- Assistance with identifying opportunities for increasing natural allies a person has to rely on, including opportunities for the development of valued social relationships, and expanding unpaid sources of support in addition to, or reduce reliance on, paid services.

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

- These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an indefinite basis, nor should these services be provided for companionship purposes only.
- The focus of these services should be customized to the specific goal(s) of the person receiving these services.
- Transportation of the person receiving this service is not included in the rate or in the scope of expectations for the Peer Specialist.
- The Support Coordinator is responsible for monitoring the satisfaction of the person served and outcomes resulting from this service on a monthly basis and documenting these things in the person's record.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Peer Specialist		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Peer Specialist	None	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities

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			Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served Prior to service delivery, successfully complete at least eight (8) hours of training in best practices for offering Peer Specialist Services for each of the topical areas covered by this service that the Peer Specialist wishes to be qualified to address; and Complete no less than two (2) hours of annual refresher training for each of the topical areas covered by this service that the Peer Specialist wishes to be qualified to address. Must have successfully directed their own Person-Centered Planning process and self-directed their own services for a minimum of one (1) year Must have successfully obtained individualized integrated employment at a competitive wage, and/or utilizes independent/supported living options.
DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Peer Specialist	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification

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HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self
Category 3:	Sub-Category 3:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 4:	Sub-Category 4:
13 Participant Training	13010 participant

Service Definition (Scope):

Service Title: **Family Empowerment and Systems Navigation Counseling**

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:
Family Empowerment Counselor and Systems Navigator Services matches the involved family members (e.g. support/care givers; legal guardians) of an individual with intellectual disabilities with a local professional or similar reputable adult with broad knowledge of the variety of programs and local community resources that are available to an individual with intellectual disabilities and his/her family. The Family Empowerment Counselor and Systems Navigator Services are intended to be time-limited services that involve assessment of the individual's situation (including needs, goals), assessment of the family's specific goals and needs for information, assistance, and referral to address the individual and family's situation. The service further includes, researching as needed, and sharing of the identified information, connecting the family with assistance, and making referrals as appropriate. The goal of the service is to empower the family with the information, connections and referrals they need, and to work with the family to increase their skills in problem-solving and leveraging available programs and community resources, including Support Coordination. This service is also intended, through temporary peer supervision, to facilitate an opportunity for interested family members, who have received this service, to become providers of this service themselves in order to grow the network of providers of this service over time.

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

- These services are intended to support appropriate assessment of goals/needs following by the timely sharing of information, sources of assistance, and referrals to address the individual and family's situation; therefore, this service should not be provided on an indefinite basis, nor should these services be provided for companionship or purposes only.
- The focus of these services should be customized to the specific goal(s) of the individual receiving these services.
- Transportation of the person or family members of the person receiving this service is not included in the rate or in the scope of expectations for the Navigator delivering this service.

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- The Support Coordinator is responsible for monitoring the satisfaction of the person and family served and outcomes resulting from this service on a monthly basis and documenting these things in the person's record.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian	

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Family Empowerment Counselor		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Family Empowerment Counselor	None	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served Prior to service delivery, successfully complete at least eight (8) hours of training in best practices for working with families, working with individuals with intellectual disabilities, family empowerment strategies and community mapping techniques; and Complete no less than two (2) hours of annual refresher training.

DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family Empowerment Counselor	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Natural Support or Caregiver Education and Training**

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:

This service provides reimbursement up to $500 per year to training entities to offset the costs of educational materials, training programs, workshops, conferences and other similar opportunities that help a family caregiver or other vital, unpaid care and support giver for a waiver participant to:

- Understand the disability of the person supported;
- Achieve greater competence and confidence in providing supports;
- Access community and other resources and supports;
- Develop strong advocacy skills; and

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- Support the person in developing and using self-advocacy skills.

The intent of the service, when provided, is to provide education and support to the care/support giver that preserves the family unit and/or involvement of a similar unpaid, care and support giver for the person. This service is also intended to increase the confidence, stamina and resourcefulness of the family caregiver or similar care and support giver in the person's life.

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

- Natural Support or Caregiver Education and Training is offered only for a family caregiver or similar care and support giver who is providing unpaid support, training, companionship, care or supervision for a person participating in waiver services.
- Education and training activities are based on the unique needs of the family caregiver or other unpaid care and support giver and are specifically identified in the Person-Centered Plan prior to authorization.
- Reimbursement of up to $500 per year is for each waiver participant, regardless of how many family caregivers or other vital, unpaid care and support givers may be involved in the person's life. The funds may be used to benefit more than one care or support giver involved with the waiver participant.
- Reimbursement will only be made after documentation of training expenses are submitted to DMH/DDD and approved by the Support Coordinator.
    - Travel and lodging to attend training cannot be reimbursed.

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(s) *(check one or both)*:	☐	Individual. List types:	☐	Agency. List the types of agencies:
	N/A		N/A	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
N/A			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

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N/A		

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	Sub-Category 3:
13 Participant Training	13010 participant
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Financial Literacy and Work Incentives Benefits Counseling**

Enrollment Group(s):
Essential Family Preservation Supports (Financial Literacy Counseling only)
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

For a waiver participant of any age living at home with the family who is providing a home and/or natural care or support for the waiver participant, the Financial Literacy component of this service is designed to:

- Support continuity of stable housing, community tenure, and natural supports for the waiver participant by supporting the person and/or the person's family in sustaining and improving its economic self-sufficiency;
- Enable improvement of economic self-sufficiency necessary to continue to provide a home and/or natural support to a person enrolled in the waiver;
- Assist with evaluating financial health and current level of financial literacy, and making a plan with specific strategies to improve financial health and increase level of financial literacy;
- Teach financial literacy skills

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- Assist with access to community resources available to address improvement of economic self-sufficiency and financial health, including ability to sustain the family home.

For a waiver participant sixteen (16) or older (and legal guardian and/or involved family, if applicable), this service may include Financial Literacy and Work Incentive Benefits Counseling as appropriate to the needs of the person. Financial Literacy services are specifically for waiver participants sixteen (16) and older who are living independently or in a supported living arrangement and are intended to:

- Enable a person to improve his/her economic self-sufficiency necessary to continue to maintain independent/supported living in the community;
- Assist a person with evaluating his/her financial health and current level of financial literacy, and making a plan with specific strategies to improve his/her financial health and increase his/her level of financial literacy;
- Teach the person financial literacy skills
- Assist the person to access community resources available to the person that address improvement of economic self-sufficiency and the person's financial health, including ability to sustain the independent/supported living arrangement.

Work Incentive Benefits Counseling is designed to:

- Provide general introductory education that identifies and explains the multiple pathways to ensuring individualized integrated competitive employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This general introductory education should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated competitive employment.
- Provide a thorough Work Incentive Benefits Analysis addressing the benefits, entitlements, subsidies and services the individual receives to assess the impact that income from employment may have on continued eligibility and benefit amounts, including health coverage. Individuals are informed of work incentives, provisions that are designed to help protect benefits while working (i.e. Impairment Related Work Expense, Earned Income Exclusion, Plan for Achieving Self Support (PASS), Continued Medicaid and Extended Medicare, as well as other benefit programs for which the individual may be eligible. The information is intended to assist the person in making informed decisions about how much they can work and earn through individualized integrated competitive employment.
- Both the general introductory education service and the Work Incentive Benefits Analysis must provide education and information on the income reporting requirements for public benefit programs, including the Social Security Administration.
- This service may also include assistance with the submission of a PASS Plan or Impairment Related Work Expenses (IRWE) to the Social Security Administration depending on the needs of the individual.

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

- For Financial Literacy services, there must be a documented and current concern about the ability to sustain the family home or the person's home.
- For Work Incentive Benefits Counseling, in addition to ensuring this service is not otherwise available to the individual within 90 days under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), the Waiver may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

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- Introductory general education as part of Work Incentive Benefits Counseling shall be limited to individuals ages 16-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of four (4) hours of face-to-face service. This component of service can be reauthorized once per waiver year.
- Work Incentive Benefits Analysis, as part of Work Incentive Benefits Counseling, shall be limited to individuals ages 16-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of twenty-three (23) hours of service covering all necessary steps for production of a Work Incentive Benefits Analysis report. This component of service may be authorized no more than once every three (3) years and only if circumstances have significantly changed since the prior authorization, warranting a new analysis.
- Assistance with development of a PASS Plan or IRWE is limited to a total of fifteen (15) hours of service covering all necessary steps involved for submission to, and approval by, the Social Security Administration. This component of service may not be authorized more than once every three (3) years and only if the person's circumstances warrant this and Social Security Administration approval is likely.
- PRN Problem-Solving services for someone to maintain individualized integrated competitive employment: up to four (4) hours per situation requiring PRN assistance. This service may be authorized up to three (3) times per year if necessary for the individual to maintain individualized integrated competitive employment.
- The service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation and/or interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Financial Literacy Counselor		DDD Certified Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial Literacy Counselor	None	See Other.	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

			Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served Minimum of Associates Degree in human service or related field; and For Work Incentives Benefits Counseling: Must be a certified Community Work Incentives Coordinator (CWIC) or Work Incentives Practitioner (WIP); and For Financial Literacy Counseling: Prior to service delivery, successful completion of the "Building of the Financial Well-Being of Persons with Disabilities" curriculum from National Disability Institute offered by qualified trainer from DMH/DDD. Successfully complete no less than four (4) hours of annual continuing education (for Work Incentives Benefits Counselor) or refresher training (for Financial Literacy Counselor) provided by DMH/DDD.
DDD Certified Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Literacy Counselor	ADMH DDD Certification	Annually
DDD Certified Provider	ADMH DDD Certification	Annually

State:	
Effective Date	

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self
Category 2:	Sub-Category 2:
13 Participant Training	13010 participant
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Counseling and Assistance with Alternatives to Full Legal Guardianship**

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 17+)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A one-time service that provides consultation, education and assistance to a parent(s) or other involved family member(s) who want to understand the alternatives to seeking full guardianship of an adult child or family member enrolled in the waiver (e.g. financial power of attorney; health care power of attorney; health care representative; supported decision-making arrangement; limited/partial legal guardianship). This service shall be provided in a manner that seeks to preserve the rights and freedoms of the person to the maximum extent possible and appropriate. This service begins with education and consultation from a qualified professional to help ensure understanding of the array of options available, including less restrictive options that can be used to preserve the person's rights and freedoms to the maximum extent possible and appropriate, while addressing decision making needs.

Reimbursable services may then include: (1) assistance with completing necessary paperwork and processes to establish an alternative to conservatorship, such as supported decision making, limited (and revocable) power of attorney, health care proxy, or trust; or limited or full or conservatorship that is specifically tailored to the individual's capacities and needs, if it is determined to be the least restrictive alternative; (2) evaluating the appropriateness of a decision making instrument currently in place and assistance with costs associated with terminating or revoking a conservatorship when less restrictive options would be appropriate; and (3) training associated with decision-making support.

State:	
Effective Date	

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

- For a waiver participant where full legal guardianship is an imminent possibility in the absence of this service, the authorization is limited to a one-time authorization of up to twelve (12) hours of face-to-face counseling and assistance.
- For a waiver participant under full legal guardianship, authorization of up to twenty (20) hours of face-to-face counseling and assistance is available in a situation where a person and/or his/her appointed legal guardian, holding full legal guardianship, wishes to pursue restoration of the person's rights through implementation of an alternative(s) to full legal guardianship.
- This service does not include payment of legal or similar types of fees to establish legal guardianship or set up any alternatives to legal guardianship.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Guardianship Counselor		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Guardianship Counselor	None	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served Must have evidence of training, certification and/or current knowledge of

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			the range of alternatives to guardianship and have current knowledge of published resources available on these alternatives. Must have at least one (1) year of experience working as or with an attorney who handled cases involving legal guardianship. Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities. Must hold at least a bachelor's degree from an accredited institution in a human services or legal field.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Guardianship Counselor	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	Sub-Category 2:
13 Participant Training	13010 participant
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	

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Service Title: **Positive Behavior Supports**

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Expertise, training and technical assistance in evidence-based positive behavior support strategies to assist natural, co-worker and/or paid staff in supporting individuals who have behavioral support needs. Positive Behavior Supports are designed to improve the ability of unpaid natural supports and paid direct support staff to carry out therapeutic interventions. As needed, providers of Positive Behavior Supports conduct assessments, develop a person's behavior support plan and train/consult with unpaid caregivers and/or paid support staff who are implementing the person's behavior support plan, which is necessary to facilitate the person's successful participation in the community, in employment and to ensure the person can remain in his/her current community living situation or transition to a less restrictive living situation. Service includes:

1. Assessment to inform the development of behavior support plans for settings where needed (home; work; community), including methods for evaluating effectiveness.
   A Functional Assessment will be facilitated by the provider and will include:
   i. Interviews with the participant, team leaders, staff, guardian, and professionals across settings.
   ii. A review of background information.
   iii. Evaluation of interviews to examine function of behavior.
   iv. The identification and assessment of previously used strategies for effectiveness.
   v. The identification of staff/caregiver training needs.
   vi. The collection of data on behaviors to establish a baseline.

- Based on the needs and goals of the individual, development of a home and/or community and/or worksite behavior support plan and/or intervention plan. These plans should incorporate strategies for preventing negative behaviors, identify replacement behaviors, describe how staff/natural support should intervene in a behavioral situation and identify desired fading procedures if necessary. These plans should be understandable to the staff/natural supports expected to implement them. Plans may include recommendations for assistive technology/equipment, workplace and community integration site modifications and clearly defined behavioral interventions.

- Training and technical assistance to carry out the behavior support plan and monitoring of the person and the natural support/staff in the implementation of the plans.
  The provider will identify training needs and outline a training plan for staff/unpaid caregivers.
  i. Training will include instruction about implementation of the behavior plan in the context of providing other services included in the person's Person-Centered Plan, and guidance, as necessary, to safely maintain and support the person in the relevant community settings. Training must be aimed at assisting the unpaid caregiver/staff in meeting the needs of the person.

- Following the completion of identified training and technical assistance, the provider will provide consultation/follow up 1-2 times per month to examine plan implementation and effectiveness. As

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needed, revisions of the plan will be done to assure progress toward achievement of desired outcomes. Tele-consulting through the use of two-way, real time-interactive audio and video between places of greater and lesser clinical expertise to provide behavioral consultation services when distance separates the behavioral expert from the person.

This service may also include time-limited consultation with the person and his/her Person-Centered Planning team to consider available service providers and potential providers and assist the person to identify and select providers that can meet the unique needs of the member and to identify additional supports necessary to implement behavior plans and perform therapeutic interventions.

As needed, this service is also used to allow the behavioral specialist to be an integral part of the person-centered planning team, as needed, to participate in team meetings.

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

- This service does not supplant or duplicate services available through the Medicaid State Plan, EPSDT, or through section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).
- This service does not supplant or replace services provided under the Medicaid State Plan through a Mental Health Center for an individual with an intellectual disability who has a diagnosis of a mental illness or substance use disorder.
- The Positive Behavior Supports specialist and the paid direct support staff are able to bill for their service time for an individual concurrently.
- The implementation of Positive Behavior Supports (and any associated Behavior Support Plans) that involve restrictions must be regularly monitored on an ongoing basis by the qualified provider of Positive Behavior Supports.
- Positive Behavior Supports must be implemented to comply with the ADMH Division of Developmental Disabilities Behavioral Services Procedural Guidelines.
- Positive Behavior Supports is limited to no more than 480 units per year.
- A Community Services Director may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered service, or transition to an enrollment group with a higher expenditure cap.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s)	X	Individual. List types:	X	Agency. List the types of agencies:
	Positive Behavior Supports Specialist		Certified DDD Provider	

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(check one or both):		

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Positive Behavior Supports Specialist	None	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Worked in the Intellectual/Developmental Disability (IDD) field for five (5) years or more, two of which much have been at a professional level in a position that addressed challenging behavior or who worked in a related field (e.g., mental health); Holds an appropriate BA/BS level degree, master's degree, other advanced degree above the level of Masters or equivalent experience in a field related to human services, such as psychology, social work, behavioral, disabilities, or rehabilitation psychology; Has completed training in positive behavior supports and/or behavioral psychology and/or applied behavioral science.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Positive Behavior Supports Specialist	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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).

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HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Minor Home Modifications**

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:

Modifications to the home, required b the individual PCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Such modifications include:

- Provision and installation of certain home mobility aids, including:
  - A wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp
  - Handrails for interior or exterior stairs or steps
  - Grab bars and other devices
- Minor physical adaptations to the interior of the individual's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, including:
  - Widening of doorways
  - Modification of bathroom facilities
  - Installation of electric and plumbing systems necessary to accommodate any medical equipment/supplies needed for the welfare of the individual

All services shall be provided in accordance with applicable state or local building codes.

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

- Adaptations that are necessary to support the person to work at home in individualized, integrated competitive employment can be covered but only if they are not the responsibility of the person's employer, if applicable, under the Americans with Disabilities Act and/or if funding to cover these

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modifications is not available to the individual from another source (e.g. Alabama Division of Vocational Services; Alabama Workforce System).

- Any minor home modification must be documented, including documentation of assessed need that justifies the modification, in the person's Person-Centered Plan, to include the specific rationale for their implementation
- An evaluation by an appropriate professional (e.g., a Physical Therapist) may be necessary to assist in the determination of structural requirements.
- Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.
- Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios.
- Adaptations that add to the total square footage of the home are excluded from this benefit.
- Minor Home Modifications do not include the installation of equipment for Remote Supports monitoring which are covered under Remote Supports.

Minor Home Modifications are limited to $5,000 per waiver year. A Community Services Director, with approval from DDD Central Office, may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered services, or transition to an enrollment group with a higher expenditure cap.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Authorized Contractor

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Authorized Contractor	Must meet all applicable state (Alabama Code 230-X-1) and local	None	Must meet all construction, wiring, and/or plumbing building codes, as applicable.

	licensure requirements.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Authorized Contractor	DDD Fiscal Management	Upon selection

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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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17030 housing
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Housing Counseling Services**

Enrollment Group(s): Seamless Transition to Adulthood Supports (for ages 18-22, if needed)
Family, Career and Community Life Supports

Definition:

Services which provide assistance to a person when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of Housing Counseling Services is to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the individual, and promotes community inclusion. Housing Counseling Services include counseling and assistance to the individual, based on individual needs and a plan reflecting these needs, in the following areas:

- Exploring both home ownership and rental options;

- Exploring both individual and shared housing situations;
- Identifying financial resources and determining affordability;
- Identifying how earned income, or an increase in earned income, could impact choice, access and affordability of housing options
- Identifying preferences of location and type of housing;
- Identifying accessibility and modification needs;
- Locating available housing by educating and supporting the person to learn how to search for available housing and/or conducting searches on behalf of the individual;
- Identifying and assisting with access to financing if homeownership is goal;
- Identifying and assistant with access to rental subsidies if renting is goal;
- Educating the person on the rights and responsibilities of a tenant, including how to ask for reasonable accommodations and modifications, how to request repairs and maintenance, and how to file a complaint if necessary; and,
- Planning for ongoing management and maintenance if homeownership is goal.

Housing Counseling Services are time-limited services but are not one-time services and may be accessed more than once if an individual's needs dictates this.

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

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Housing Counselor		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Housing Counselor	None	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities

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			Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served Must have specialized training, certification and/or relevant experience in housing issues and how these impact people with disabilities.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Housing Counselor	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17030 housing
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
Service Title:	**Housing Start-Up Assistance**
Enrollment Group(s):	Seamless Transition to Adulthood Supports (for ages 18-22, if needed) Family, Career and Community Life Supports

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Definition:
A service intended to provide essential services and items needed to establish an integrated community living arrangement for persons relocating from an institution or a provider owned or controlled residential setting. Housing Start-Up Assistance is intended to enable the person to establish an independent or supported living arrangement. Allowable costs include:

- Deposit required for a leased or rented living arrangement
- Initial fees and/or deposits to establish utility service for water, heat, electricity, phone
- Purchase of basic and essential items needed to establish a safe and secure home:
  - External locks and keys
  - Smoke and carbon monoxide detectors
  - Fire extinguisher
  - Flashlight
  - First Aid Kit
- Moving costs

Housing Start-Up Assistance may also include person-specific services and supports that may be arranged, scheduled, contracted or purchased, which support the person's successful transition to a safe, accessible independent or supported living situation:

- Moving service
- Packing supplies
- Cleaning service
- Electronics set-up

No institutional length of stay requirement exists to access this service.

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

- Housing Start-Up Assistance costs in excess of $1,000 per person, not including deposit required for executing a lease/residency agreement, require prior approval from DMH/DDD central office for expenditures or purchases. Authorization of this service more than once every three (3) years requires prior approval from DMH/DDD central office.
- Services or items covered by this service may not be purchased more than 180 days prior to the date the person relocates to the new independent/supported living arrangement.
- Housing Start-Up Assistance services exclude:
  - Purchase of food;
  - Payment of rent beyond advanced payment (e.g. a deposit) of one month's rent required at the time of signing a lease or residency agreement;
  - Purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service);
  - Purchase of service agreements or extended warranties for appliances or home furnishings;
  - Home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided via other sources or the Minor Home Modifications waiver service; and,

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- Housekeeping services provided after occupancy which, if needed, may be provided through other sources or other waiver or Medicaid state plan services.
- When this service is provided to an individual transitioning from a residential institution to a community-based independent/supported living setting, the service is not billed until the date the individual leaves the institution and begins waiver services.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☐	Agency. List the types of agencies:
	N/A		N/A	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
N/A			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
N/A		

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

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Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Supported Living Services**

Enrollment Group(s): Seamless Transition to Adulthood Supports (for ages 18-22, if needed)
Family, Career and Community Life Supports

Definition:

Services that include training and assistance in maintaining a home of one's own: a residence not owned or controlled by a waiver service provider or a residence that is not the home of a family caregiver. The home may be shared with other freely chosen housemates who may or may not also receive waiver services and/or have a disability. Supported Living Services are provided with the goal of maximizing the person's independence and interdependence with housemates and natural supports, using a combination of teaching, training, technology and facilitation of natural supports. Supported Living Services are delivered according to the person's Supported Living Service Plan (a part of the PCP) and may include supports for any of the following:

- Maintaining home tenancy or ownership;
- Managing money, budgeting and banking;
- Planning and preparing meals;
- Shopping for food and home supplies;
- Maintaining personal appearance and hygiene;
- Health and wellness goals and activities;
- Developing and maintaining positive relationships with neighbors; and,
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law.
- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Implementation of behavioral support plans developed by qualified behavioral specialists; and
- On-call supports for as-needed or emergency assistance.

This service is intended for persons who, with technology, natural supports and good advanced planning, need intermittent and/or on-call staff support to remain in their own home and who do not need and will not benefit from around-the-clock staffing. Supported Living Services are differentiated from Personal Assistance by virtue of the 24-hour on-call access to supports on an as-needed/emergency basis that are part of

Supported Living Services. It is the responsibility of the provider to ensure that the person has an emergency preparedness plan in place at all times, this plan is shared with the Support Coordinator and others on the Person-Centered Planning team, and the person is supported to learn and practice this plan at regular intervals.

All individual goals/objectives for Supported Living Services, along with a description of needed Supported Living Services supports to achieve them, shall be established via the person-centered planning process and documented in the Supported Living Service Plan which is made part of the Person-Centered Plan and which determines the specific weekly rate paid for the service. The Supported Living Service Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Availability of natural supports
- Ability to utilize technology
- Ability to rely on housemates, neighbors, etc.
- Other services the person may be receiving, regardless of funding source

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

- A person receiving Supported Living Services shall not be eligible to receive Personal Assistance-Home, Personal Assistance-Community, Independent Living Skills Training, Breaks and Opportunities (Respite), Adult Family Home or Community-Based Residential Services as separate services.
- Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. Transportation to/from medical appointments and services is covered under Non-Emergency Medical Transportation available through the Medicaid State Plan and not through this service or the waiver.
- A minimum of one (1) face-to-face service visit to the residence, lasting at least one hour, is required each week for each person who receives Supported Living Services, in addition to on-call, around-the-clock availability of the provider staff, in the event unplanned or emergency supports are needed.
- A person receiving Supported Living Services may receive Remote Supports to maximize the use of technology supports. The Supported Living Service Plan must reflect the use of Remote Supports and the monthly rate paid for this service must take account of the use of Remote Supports and the role the Supported Living Service provider may play in the implementation of Remote Supports.
- Persons receiving Supported Living Services may choose to receive this service in a shared living arrangement involving a maximum of three (3) persons per residence receiving this service. Each person may require differing levels of support and/or types of waiver services in addition to Supported Living Services as detailed in their Person-Centered Plan and Supported Living Services Plan. Other individuals sharing the residence and receiving Supported Living Services may participate in different HCBS programs, so long as the provider is qualified to safely and appropriately meet the needs of each person in the residence.
- The service shall not be provided in a home where the person lives with family members (e.g., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption), unless such family members are also persons receiving waiver services.
- Certain family members of the person supported (e.g., spouse, parent, child, or legal guardian, regardless of relationship) shall not be reimbursed to provide Supported Living Services. Other family

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members may be reimbursed to provide the service, if they otherwise meet provider qualifications and hiring requirements or are employed by an approved provider.

- The reimbursed rate for each unit of service is determined by formal assessment. The determined reimbursed rate for each unit of service will be for a period defined by the formal assessment process, with reassessment occurring no less than every six (6) months as a part of the Person-Centered Plan and the Supported Living Services Plan semi-annual review, or more frequently, in the event of changes in needs or circumstances that require changes to the Supported Living Services Plan.
- Supported Living Services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service shall not include the cost of maintenance of the dwelling.
- Residential expenses (e.g., telephone, cable television, food, rent, mortgage, insurance, etc.) shall be paid by the person(s) supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall not co-sign a lease or rental agreement for the person's place of residence and will sign an agreement with the person ensuring that the person will not be required to move if the person chooses a different Supported Living Services provider at any point, and if such a decision is made, the Supported Living Services provider will work with the person and the new provider to ensure an orderly, well-planed transition with no gap in supports for the person.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Supported Living Worker		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Worker	None	None	Minimum qualifications as defined in rule and/or policy.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supported Living Worker	ADMH DDD Certification	Annually

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Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	

Service Title: **Adult Family Home**

Enrollment Group(s): Supports to Sustain Community Living

Definition:
A community-based alternative to residential habilitation service that enables up to three persons receiving this service to live in the home of trained host family caregivers (other than the person's own family) in an adult foster care arrangement. In this type of shared living arrangement, the person(s) moves into the host family's home, enabling the person(s) to become part of the family, sharing in the experiences of a family, while the trained family members provide the individualized services that:

- Support each person's independence and full integration in their community;
- Ensure each person's choice and rights; and
- Support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes.

Adult Family Home services are individualized based on the needs of each person, as specified in the Adult Family Home Plan and may include supports for any of the following:

- Assistance, including hands-on assistance only as needed by the individual, with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing activities of daily living;

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- Assistance, including hands-on assistance only as needed by the individual, with instrumental activities of daily living such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing instrumental activities of daily living;
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law;
- Achieving health and wellness goals as outlined in the Person-Centered Plan;
- Scheduling and attending appropriate medical services appointments with transportation reimbursement through Non-Emergency Medical Transportation under the Medicaid State Plan;
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services, only as needed, for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.;
- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Developing and maintaining positive relationships with neighbors;
- Assistance to participate fully in community life, including faith-based, social, and leisure activities selected by the person;
- Coordinating with other service providers for the person if the person is receiving other services, regardless of funding source, to pursue employment or educational goals and opportunities;
- Assistance with exercising civil and statutory rights (e.g. voting);
- Implementation of behavioral support plans developed by qualified behavioral specialist;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Assistance with effectively using police, fire, and emergency help available in the community to the general public;
- Supervision and companionship only if needed by the individual.

All individual goals/objectives for Adult Family Home services, along with a description of needed Adult Family Home supports to achieve them, shall be established via the Person-Centered Planning process and documented in the Adult Family Home Service Plan which is made part of the Person-Centered Plan and which determines the specific monthly rate paid for the service. The Adult Family Home Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Ability to utilize technology
- Ability to rely on natural supports
- Other services the person may be receiving regardless of funding source

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Training and supervision of the host family caregivers by DMH/DDD Regional Office staff person qualified as QDDP/QIDP shall ensure the host family caregivers is prepared to carry out the necessary training and support functions to implement the Adult Family Home Service Plan and assist the individual to successfully achieve the goals/objectives identified in the Plan. Progress toward the goals/objectives will be documented by the provider, with corresponding adjustments to the Adult Family Home Service Plan implemented accordingly, as determined by the person and his/her Person-Centered Planning team.

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

- The provider's home must be integrated in the greater community and not isolate the person from the opportunity to interact with members of the broader community and participate fully in community life. The provider shall ensure they meet all of the requirements of the HCBS Settings Rule which includes but is not limited to supporting full access to the greater community, opportunities to 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.
- A person receiving Adult Family Home services shall not be eligible to receive Personal Assistance-Home, Independent Living Skills Training, Adult Family Home or Community-Based Residential Services as separate services.
- Personal Assistance-Community and/or Community Integration Connections and Skills Training shall not duplicate any supports included as part of Adult Family Home services.
- Breaks and Opportunities (Respite), as needed, shall be available to preserve the Adult Family Home living situation for the person and shall be taken account of in the assessment that determines the reimbursement rate paid for Adult Family Home services.
- A person receiving Adult Family Home services may receive Remote Supports to maximize the use of technology supports. The Adult Family Home Plan must reflect the use of Remote Supports and the monthly rate paid for this service must take account of the use of Remote Supports and the role the Adult Family Home provider may play in the implementation of Remote Supports. Remote supports shall not be utilized for periods of time when the Adult Family Home providers are present in the home with the person receiving services unless approval from DMH/DDD central office is received in advance.
- Transportation: Medical and non-medical transportation support will be determined as part of the assessment process. Medical transportation is covered separate from the waiver under Non-Emergency Medical Transportation available through the Medicaid State Plan. Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. If individual non-medical transportation needs covered under this service exceed a 20-mile radius and more than five trips per month, this would be considered excessive transportation and can be captured as such on the assessment. Service workers may transport consumers in their own vehicles as an incidental component of this service.
- Family members (e.g., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption) are not eligible providers of Adult Family Home services. A person residing with an individual and being paid for Personal Assistance-Home services may not be an eligible provider of Adult Family Homes services.

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- As a part of the Person-Centered Plan, the Adult Family Home services must be reviewed at least semi-annually, or more frequently, in the event of changes in needs or circumstances that require changes to the Adult Family Home Plan.
- Adult Family Home services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service does not include the cost of maintenance of the dwelling.
- The person's appropriate portion of residential expenses (e.g., telephone, cable television, internet, food, electricity, heating/cooling, water, etc.) shall be paid by the person supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall provide and execute with the person, a legally enforceable lease or rental agreement that meets HCBS Settings Rule standards.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	☐	Agency. List the types of agencies:
	Host Family Caregiver		N/A	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Host Family Caregiver	None	None	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Host Family Caregiver	ADMH DDD Certification	Annually

C-1/C-3: Service Specification

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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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Community-Based Residential Services**

Enrollment Group(s): Supports to Sustain Community Living
Unit of Authorization: Per Day

Definition:
Community-Based Residential Services enable an individual to avoid institutionalization and live in a community setting that provides services to:

- Support the person's maximum independence, autonomy and full integration in their community;
- Ensure each person's rights and abilities to make choices; and
- Support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes.

Community-Based Residential Services are provided for up to four individuals in a dwelling which may be rented, leased, or owned by the provider. The person has the right to a legally enforceable lease or rental agreement with the provider that offers the same appeal rights and eviction protections as is required under state landlord-tenant law.
This service offers individualized services and supports that enable the person supported to acquire, retain, and improve skills necessary to reside in the least restrictive residential setting possible. The setting in which the service is provided must be an ADMH-certified, community-based residential setting which supports each person's independence and full integration into the community and ensures each person's basic needs (e.g., food, clothing, etc.), choice, rights, safety and security. Community-Based Residential Services provide care, supervision, and skills training in activities of daily living, home management and community integration.
The service includes the following:

- Assistance, including hands-on assistance only as needed by the individual, with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility;

- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing activities of daily living;
- Assistance, including hands-on assistance only as needed by the individual, with instrumental activities of daily living such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing instrumental activities of daily living;
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law;
- Scheduling and attending appropriate medical services appointments with transportation reimbursement through Non-Emergency Medical Transportation under the Medicaid State Plan;
- Assistance with achievement of health and wellness goals and related activities;
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services, only as needed, for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.;
- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Developing and maintaining positive relationships with neighbors;
- Assistance to participate fully in community life, including faith-based, social, and leisure activities selected by the person;
- Coordinating with other service providers for the person if the person is receiving other services, regardless of funding source, to pursue employment or educational goals and opportunities;
- Assistance with exercising civil and statutory rights (e.g. voting);
- Implementation of behavioral support plans developed by a qualified behavioral specialist;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Assistance with effectively using police, fire, and emergency help available in the community to the general public;
- Supervision and companionship only if needed by the individual.

All individual goals/objectives for Community-Based Residential Services, along with a description of needed services and supports to achieve them, shall be established via the Person-Centered Planning process and documented in the Community-Based Residential Services Plan which is made part of the Person-Centered Plan and which determines the specific daily rate paid for the service. The Community-Based Residential Services Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Ability to utilize technology
- Ability to rely on natural supports

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- Other services the person may be receiving regardless of funding source

Training, mentoring and supervision of the provider's direct support staff shall ensure the staff is prepared to carry out the necessary support and training functions to achieve the goals in the Community-Based Residential Services Plan, which supports the individual to have the lifestyle, routine and opportunities they desire. Progress toward these goals will be documented by the provider, with corresponding adjustments to the Plan implemented accordingly, as determined by the person and his/her Person-Centered Planning team.

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

- The provider's home must be integrated in the greater community and not isolate the person from the opportunity to interact with members of the broader community and participate fully in community life. The provider shall ensure they meet all of the requirements of the HCBS Settings Rule which includes but is not limited to supporting full access to the greater community, opportunities to 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.
- A person receiving Community-Based Residential services shall not be eligible to receive Personal Assistance-Home, Independent Living Skills Training, Personal Assistance-Community, Adult Family Home or Breaks and Opportunities (Respite) as separate services.
- Community Integration Connections and Skills Training shall not duplicate any supports included as part of Community-Based Residential services.
- Transportation: Medical and non-medical transportation support will be determined as part of the assessment process. Medical transportation is covered separate from the waiver under Non-Emergency Medical Transportation available through the Medicaid State Plan. Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. If individual non-medical transportation needs exceed a 20-mile radius and more than five trips per month, this would be considered excessive transportation and can be captured as such on the assessment. Service workers may transport consumers in their own vehicles as an incidental component of this service.
- Family members (i.e., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption) are not eligible providers of Community-Based Residential services.
- As a part of the Person-Centered Plan, the Community-Based Residential services must be reviewed at least semi-annually, or more frequently, in the event of changes in needs or circumstances that require changes to the Community-Based Residential Services Plan.
- Community-Based Residential services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service does not include the cost of maintenance of the dwelling.
- The person's appropriate portion of room and board expenses shall be paid by the person supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall provide and execute with the person, a legally enforceable lease or rental agreement that meets HCBS Settings Rule standards.

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Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E		X	Provider managed		
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Direct Support Personnel		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Direct Support Personnel	None	None	Minimum qualifications as defined in rule and/or policy.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Direct Support Personnel	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
11 Other Health & Therapeutic Services	11090 physical
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

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Service Definition (Scope):

Service Title: **Physical Therapy**

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Physical therapy is treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services must begin with the PT evaluation that, if necessary, results in the development of a treatment plan.

The evaluation of an individual to determine level of functioning, need for therapy, an all information necessary for the development of the treatment plan. The treatment plan should outline the frequency of service (maximum one session per week in combination with home-based program implementation natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

Physical therapy involves applying diagnostic and prognostic tasks and providing treatment training programs that are designed to: preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation. The PT is expected to recommend exercises to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of PT is achieved and gains are sustained over time, after and if PT sessions have ended. To this end, the PT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the recipient to experience maximum benefit of PT, and ensure gains are sustained over time, after PT sessions have ended. The PT should teach the primary natural/paid direct support providers how to continue all relevant exercises that can be done at home or other appropriate integrated community setting(s), including ROM exercises for the participant.

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

- Physical Therapy requires a physician's prescription and documentation in the form of an initial evaluation and development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- Services must be listed on the Plan of Care and be provided and billed in 15-minute units of service.
- Physical therapy is limited to no more than 5O hours or 200 units annually and no more than one session a week. If it appears that more frequent physical therapy is needed, and the benefit from

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which cannot be accomplished through natural/paid direct support providers, trained by the PT, implementing a home or community-based PT program in-between PT sessions, the PT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 50 hours, or 200 units will be allowed per individual per waiver year.

- Physical therapy under the waiver is not available to children under the age of 21 because the service is covered under State Plan EPSDT services.
- Medicaid State Plan physical therapy in a hospital outpatient setting must be utilized first or documentation maintained it was confirmed unavailable to or previously exhausted by the individual.
- Service delivery in less than 1:1 ratio is not permitted.
- Documentation: Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered, including detailed documentation of what the service entailed. Physical therapist must sign each treatment note and must describe progress made on goals established in the treatment plan.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
		Physical Therapist		Certified DDD Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	Physical Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec.34-24-212.	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and

			importance of respecting the rights of people served
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
11 Other Health & Therapeutic Services	11080 occupational
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: Occupational Therapy

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term occupation as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performance. Services must begin with the OT evaluation that, if necessary, results in the development of a treatment plan.

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The evaluation of an individual is to determine level of functioning, need for therapy, and all information necessary for the development of the treatment plan. The treatment plan should outline the frequency of service (maximum one session per week in combination with home or community-based program implementation by natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

Occupational therapy involves the application of diagnostic and prognostic tasks and treating individuals in the prescribed therapy, including treatment training programs, to secure and/or obtain necessary functioning. The OT is expected to recommend exercises to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of OT is achieved and gains are sustained over time, after OT sessions have ended. To this end, the OT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the recipient to experience maximum benefit of OT, and ensure gains are sustained over time, after OT sessions have ended. The OT should teach the primary natural/paid direct support providers how to continue all relevant exercises and activities that can be done at home or other appropriate integrated community setting(s) with the participant.

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

- Occupational Therapy requires a physician's prescription and documentation in the form of an initial evaluation and development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- Services must be listed on the Plan of Care and be provided and billed in 15-minute units of service.
- Occupational therapy is limited to no more than 50 hours or 200 units annually and no more than one session a week. If it appears that more frequent occupational therapy is needed, and the benefit from which cannot be accomplished through natural/paid direct support providers, trained by the OT, implementing a home or community-based OT program in-between OT sessions, the OT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 50 hours, or 200 units will be allowed per individual per waiver year.
- Occupational therapy under the waiver is not available to children under the age of 21 because this service is covered under the State Plan EPSDT services.
- Service delivery in less than 1:1 ratio is not permitted.

Documentation: Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered, including detailed documentation of what the service entailed. Occupational therapist must sign each treatment note and must describe progress made on goals established in the treatment plan.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	**X**	Provider managed

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Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Occupational Therapist		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist	Occupational Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-39-5.	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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).

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Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
11 Other Health & Therapeutic Services	11100 speech, hearing, and
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Speech and Language Therapy**

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Speech and language therapy includes diagnostic, screening, preventive and corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). Services must begin with the SLT evaluation that, if necessary, results in the development of a treatment plan.

The evaluation of an individual is to determine level of functioning, need for therapy, and all information necessary for the development of the treatment plan. The evaluation is customized to the individual and may include screening and evaluation of the individual's speech and hearing functions or a comprehensive speech and language evaluation. The treatment plan should outline the frequency of service (maximum one session per week in combination with home or community-based program implementation by natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

These services address improvement in speech fluency and intelligibility and development of an individual's communications skills including expressive and receptive communication skills. These services may include swallowing therapy in additional to other treatment services if the evaluation identifies this as an assessed need. The SLT is expected to recommend exercises and activities to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of SLT is achieved and gains are sustained over time, after SLT sessions have ended. To this end, the SLT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the recipient to experience maximum benefit of SLT, and ensure gains are sustained over time, after SLT sessions have ended. The SLT should teach the primary natural/paid direct support providers how to continue all relevant exercises and activities that can be done at home or other appropriate integrated community setting(s) with the participant.

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

- Services must be listed on the Plan of Care and prescribed by the participant's physician and related to a participant's particular diagnosis.
- An evaluation is required by the qualified speech therapist to determine the need for service. If there is a need for service, the speech therapist must develop the treatment plan outlining the frequency of service and length of time expected to meet outlined goals and expected outcomes. The need for service must be documented in the case record and the service must be expected to result in improvement in functioning for the waiver participant.
- Speech/Language Therapy must be due to an acute episode and should terminate once therapy becomes maintenance in nature.
- Speech and Language Therapy is limited to no more than thirty (3O) hours or 120 units annually and no more than one session a week. If it appears that more frequent SLT is needed, and the benefit from which cannot be accomplished through natural/paid direct support providers, trained by the SLT, implementing a home or community-based SLT program in-between SLT sessions, the SLT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 30 hours, or 120 units will be allowed per individual per waiver year.
- Speech and Language Therapy under the waiver is not available to children under the age of 21 because this service is covered under the State Plan EPSDT services.
- Service delivery in less than 1:1 ratio is not permitted.

Documentation: Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered, including detailed documentation of what the service entailed. The speech therapist must sign each treatment note and describe progress made toward goals established in the treatment plan.

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:		Legally Responsible Person		Relative		Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
		Speech & Language Therapist		Certified DDD Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

State:	
Effective Date	

Speech & Language Therapist	Speech Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7	None	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. Must complete training, with content preapproved by ADMH/DDD, addressing the following topics: Overview of intellectual disabilities Overview of Americans with Disabilities Act findings, purpose, history [https://www.adaanniversary.org/findings_purpose] and importance of respecting the rights of people served
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech & Language Therapist	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

State:	
Effective Date	

Service Definition (Scope):

Service Title: **Skilled Nursing**

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and must be provided by a registered professional nurse (RN), or licensed practical (LPN) or vocational nurse under the supervision of a registered nurse, licensed to practice in the state of Alabama. An RN is required to perform the supervisory visit every 60 days for an LPN providing this service.
To authorize this service, a physician's order is required followed by a Regional Office RN completing an assessment to determine if the services may be safely and effectively administered in the home or community (the place or places of service where the individual desires to receive the service). There is no restriction on the place of service except the service may not be provided in facility-based non-residential service settings or other settings that do not fully comport with the setting standards contained in the federal HCBS settings rule, including the additional standards that apply to provider owned or controlled settings. This assessment by the Regional Office RN also will identify and confirm the specific type of Skilled Nursing service needed and the amount of time needed.

Services are of two types:

1. Training and supervision provided to natural caregivers and/or direct support professionals (self-direction or agency workers) related to medical care and/or assistance with ordinarily self-administered medications to be provided by the natural caregiver or direct support professional. This training is not available to direct support professionals working for agencies providing residential services (Supported Living; Adult Family Home; Community-Based Residential Services) because payment for the nurse supervision is already included in the rate paid for those services.

2. Nursing procedures that meet the person's health needs as ordered by a physician. LPN services may provide skilled care for the recipient if a licensed physician prescribes the service. The supervising RN evaluates the participant and establishes the nursing plan of care prior to assigning services to the LPN.

Of the above two ways to provide this service, the Regional Office RN will authorize the most cost-effective option for the meeting the waiver participant's needs through this service, ensuring consistency with the physician's order in all cases. When Skill Nursing Services are provided to waiver participants living in their own homes or living with family, it is intended to focus on training of the natural caregiver and training/supervision of the person's direct support professional(s) and is not intended as a private duty nursing service.
The services of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition, the nursing note should include, as appropriate, the nurse's assessment, changes in the participant's condition, follow-up measures, communications with family, caregivers or physicians, training or other pertinent information. The nurse must sign and date the note. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

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

- Authorization of this service, and inclusion in the Plan of Care, is subject to a physician's order, based on medical necessity, and an assessment by a Regional Office RN. The need for continued medically necessary Skilled Nursing services must be ordered by the individual's physician every year at the time of the annual redetermination and a reassessment by a Regional Office RN must occur at least annually.
- This service is not available to individuals during the time they are receiving residential services, including training and supervision of direct support professionals working for agencies providing residential services (Supported Living; Adult Family Home; Community-Based Residential Services) because payment for the nursing services, including nurse supervision, is already included in the rate paid for those services.
- For individuals living with natural caregivers, the individual must require skilled nursing training, supervision and/or care which exceeds the caregiver's ability to care for the recipient. If a caregiver has been providing care that is otherwise proposed to be provided through Skilled Nursing services, there must be a negative change in the individual's condition or the caregiver's status that has occurred to warrant supplanting the caregiver's role by authorizing Skilled Nursing services.
- For individuals living with natural caregivers, a commitment on the part of the natural caregiver to participate in and complete training with the Skilled Nursing service provider is essential. The primary natural caregiver will indicate this commitment by participating in the creation, and signing, of the Skilled Nursing Agreement for Care form. Additional caregivers identified for training must be indicated on the Skilled Nursing Agreement for Care form. In the event that multiple caregivers exist who need training at separate times or in separate places, an adjustment in the hours approved for this service may be made.
- The service may not be provided in facility-based non-residential service settings or other settings that do not fully comport with the setting standards contained in the federal HCBS settings rule, including the additional standards that apply to provider owned or controlled settings.
- Skilled Nursing under the waiver is not available to children under the age of 21 because Private Duty Nursing is covered under the State Plan EPSDT services.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Nurse		Certified DDD Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

State:	
Effective Date	

Nurse	Nurses are licensed under the Code of Alabama; 1975 Sec. 34-21.	None	Minimum qualifications as defined in rule and/or policy.
Certified DDD Provider	None	DDD Provider Certification	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Nurse	ADMH DDD Certification	Annually
Certified DDD Provider	ADMH DDD Certification	Annually

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 Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Service Title: **Individual Directed Goods and Services**

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

Individual Directed Goods and Services are services are available to only those participants self-directing services who are able to save funds through negotiation of worker's employment wages. Individual goods and services include services, equipment or supplies, for the waiver participant's use

State:	
Effective Date	

and benefit,that are not otherwise provided to the individual through this waiver or through the Medicaid State Plan.

Purchases through Individual Directed Goods and Services must address an identified goal/outcome and related need in the Person-Centered Plan (including improving or maintaining the participant's opportunities for full membership in the community and/or competitive integrated employment) and meet the following requirements:

- The item or service will decrease the need for other Medicaid services and/or decrease dependency on paid support services; and/or
- The item or service will promote inclusion in the community, including enhancing family involvement; and/or
- The item or service will increase the waiver participant's independence, including improved cognitive, social or behavioral functioning, and development or maintenance of personal, social or physical skills for independence; and/or
- The item or service will increase the waiver participant's health and safety in the home or in his/her community; and/or
- The item or service will increase the waiver participant's ability to continue living in the community and avoid institutionalization

All purchases must be for items or services that are not illegal or otherwise prohibited by Federal and State statutes and regulations. All purchases can only be made if the participant does not have the funds to purchase the item or service and the item or service is not available at no cost to the participant through another source. All purchases must also be evaluated to ensure cost effectiveness as compared to other available uses of the savings account to meet the person's goals/outcomes and related needs and to assures health, safety, and welfare.

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

- Individual Directed Goods and Services are limited to those individuals self-directing services.
- The limit on amount of funds for purchases under Individual Directed Goods and Services is determined individually based on the balance of the individual's savings account at the time of the request for purchase. The savings account is maintained by the Financial Management Services Agency. The duration of this service is again based on the individual's savings account balance and the individual's participation in self-directed services. If an individual returns to traditional waiver services (stops self-directed any services) the ability to access any dollars from the savings account and utilize this service will be terminated. Additionally, dollars not utilized will be refunded to the Division of Developmental Disabilities.
- Upon enrollment in self-direction and whenever the individual's budget is reviewed and/or updated, the person may identify goods and services they wish to save for and these will be included in the savings plan and in the person's budget, and submitted to the FMSA. A copy of the savings plan will be kept in the person's record and maintained by the Support Coordinator. The FMSA will follow their process of working with the individual on procurement and reimbursement, as well as adjust the person's budget accordingly. The

FMSA will notify the Regional Office, and the Support Coordinator of the actual amount spent on Individual Directed Goods and Services monthly.

- Dollars can be accumulated past the fiscal year, however, cannot exceed $10,000.00 at any given time.
- The Support Coordinator will be responsible for monitoring the balances of the savings to ensure proper utilization. The Support Coordinator has oversight of expenditures of Individual Goods and Services and must document the need of any item or service in the case record.
- State plan services should be expended prior to the utilizing the Individual Goods and Services.
- Individual Goods and Services can be utilized prior to expenditure of waiver funds in the event there are no providers available to the participant to provide a service that can otherwise be purchased through Individual Directed Goods and Services. This must be documented in the case record.
- Items, goods or services that are not for the primary benefit of the participant are prohibited. Items, Goods and Services unrelated to the person's identified goals/outcomes and related assessed needs are prohibited.
- Experimental or prohibited treatments are excluded, as well as room and board, items solely for entertainment of recreation, cigarettes and alcohol.
- Purchase of goods or services that are illegal or otherwise prohibited by Federal and State statutes and regulations is prohibited.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative	X	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☐	Agency. List the types of agencies:
	N/A			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
N/A			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
N/A		

State:	
Effective Date	

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.*
	☐	As a primary care case management system service under a concurrent managed care authority. *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-2: General Service Specifications

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)*:

X	**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):

Executive Officers and owners of provider agencies must obtain both a statewide and a national criminal background clearance. This is a condition for initial certification. This is the responsibility of the Life Safety Division of the Operating Agency. Direct care staff must have a background check from local law enforcement, and a statewide or national check as indicated by the staff member's previous residences and work history. If a person's information as presented garners no results through local and/or state background checks, the national background check is warranted. Or, if information provided indicates experience in another state, a national background check may be warranted. This is checked as a component of the certification survey. ADMH will check the exclusion list at AMA and the OIG websites to ensure the applicant provider has not been previously debarred.

A completed application for certification must be sent by the provider/applicant to DMH Life Safety Division at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

DMH may accept a certification/license/ accreditation issued by other generally accepted recognized state or national organizations in lieu of an additional review through the DMH certification process. However, DMH reserves the right to apply DMH certification standards to areas it determines are not adequately addressed in other state or national standards. Further, the DMH reserves the right to conduct reviews, including onsite visits if appropriate, of programs that are certified/licensed/accredited by other entities where there is evidence of significant deficiencies.

The DMH Certification Office submits the application to the respective DMH Division(s) for approval according to the type(s) of services proposed by the provider.

The applicable DMH Division(s) review/approve the application and returns a copy of the approval to the DMH Facilities Certification Office. An initial Life Safety and Programmatic review is conducted, if applicable, by designated DMH representatives. Applications remain valid for up to six (6) months after receipt by DMH if the service has not been initiated by the provider or approved by DMH.

For new applicants/providers, the DMH will conduct criminal background checks on the primary operator and/or subcontractor of the program as defined in the Alabama Administrative Code, Section 580 3 23 .06(1)(a) and Section 580 3 23 .06(1)(b).

Once the provider completes the application process, and based upon its representations of

	compliance with applicable DMH standards, the provider is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit. Author: DMH Office of Certification Authority: Code of Ala. 1975, §22 50 11. All employees/volunteers/agents of the provider have reference and background checks prior to employment. Background checks cover the employer's local vicinity and state. National checks are completed when the person's job history is out of state or there is sufficient reason to warrant one (no record found in local or state systems). Resources to assist in this process include the Department of Public Safety, the Department of Public Health's Abuse Registry, as well as DMH's Term-Trac database. Drug testing is included as part of the pre-employment screening process for employees whose job duties involve the care, safety and wellbeing of people and on reasonable suspicion (for-cause) of any employee of the organization. The organization does not hire people who have been convicted of felony crimes. The Medicaid Re-enrollment process that is on-going assumes the responsibility of ensuring Executive Directors and owners are not listed in any federal exclusion lists. For participants who are self-directing services, all staff employed by the participant will have a criminal background check completed by the FMSA (Financial Management Service Agency) via internet. Nurses already are licensed by the Alabama Board of Nursing, which includes background screening. Participant's representatives may also be subject to background checks if needed. The Operating Agency reviews this information on a quarterly basis.
☐	**No.** Criminal history and/or background investigations are not required.

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)*:

☐	**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):
X ☐	**No.** The state does not conduct abuse registry screening.

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

State:	
Effective Date	

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
☐	**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). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

State:	
Effective Date	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following *(check each that applies)*:

Standard	Topic Addressed
Admission policies	☐
Physical environment	☐
Sanitation	☐
Safety	☐
Staff : resident ratios	☐
Staff training and qualifications	☐
Staff supervision	☐
Resident rights	☐
Medication administration	☐
Use of restrictive interventions	☐
Incident reporting	☐
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

State:	
Effective Date	

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:*

X	**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-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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.
X	**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 may provide waiver services if they are otherwise qualified to provide these services and they are not the legally responsible individual (i.e. the parent (biological or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; a court-appointed legal guardian for the participant; or a spouse of a waiver participant) and they do not live with the waiver participant. Relatives who are not the legally responsible individual and who live with the waiver participant may only provide Personal Assistance-Home services as described in the service limitations for this service in Appendix C-3. Documentation of services delivered is required for billing and Support Coordinators will maintain oversight of these situations to ensure services being billed are being delivered, in addition to other safeguards ADMH has in place to ensure no claims are paid for services not delivered. Legal guardians, including relatives who are legal guardians, may not provide any waiver services to the waiver participant.

☐	**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.
☐	Other policy. *Specify*:

State:	
Effective Date	

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:

Through a concurrent 1115 application ("Community First" the state is applying for a waiver of the requirements in 42 CFR §431.51. The state will maintain a provider network sufficient to meet need, including ensuring choice of at least two providers for each waiver service except Support Coordination that, through the concurrent 1115 application, will be limited to ADMH/DDD employees. The limited provider network will improve participating providers ability to thrive by participating in this waiver and will allow the Operating Agency (ADMH/DDD) to focus its resources and staff on more effectively supporting the participating providers than would be possible if the provider network was open to all willing and qualified entities that wishes to be approved waiver providers. Participant satisfaction with providers will be measured annually and Support Coordinators employed by ADMH/DDD will be responsible for informing ADMH leadership of any gaps in available, qualified and willing providers for specific services under this waiver and/or in specific geographic areas where this waiver is operating.

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.

i. 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 contracted providers that met initial licensure and/or certification standards and other standards established by Medicaid. Percentage = NUMERATOR [Number of contracted providers that met initial licensure and/or certification standards and other standards established by Medicaid] / DENOMINATOR [All new contracted providers]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Certification Surveys	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of existing contracted providers that continued to meet licensure and/or certification standards and other standards established by Medicaid. Percentage = NUMERATOR [Number of existing contracted providers that continued to meet licensure and/or certification standards and other standards established by Medicaid] / DENOMINATOR [All existing contracted providers]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Certification Surveys

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other

State:	
Effective Date	

	Specify:

Add another Performance measure (button to prompt another performance measure)

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

i. 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 non-licensed/non-certified providers that met state compliance requirements. Percentage = NUMERATOR [Number of non-licensed/non-certified providers that met state compliance requirements] / DENOMINATOR [Number of non-licensed/non-certified providers reviewed]		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Exemption letters for non-licensed/non-certified providers			
	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	

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		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.

i. 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 providers that meet training requirements in accordance with state requirements in the approved waiver. Percentage = NUMERATOR [Number of providers that meet training requirements in accordance with state requirements in the approved waiver] / DENOMINATOR [Number of providers reviewed]

State:	
Effective Date	

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Certification Surveys			
	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.*

State:	
Effective Date	

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.*

Provider agencies are certified initially and either annually or biennially, or placed on provisional status, depending on their survey score. A high score will result in a two-year certificate; a score between 80 and 89 will result in a one-year certificate; and a score below 80 will result in the agency being placed on provisional status.

Provisional status is a temporary condition which allows an agency to submit a plan of correction and, when approved, implement that plan. Provisional status may not exceed 60 days, and many such status conditions are set at 30 days or less. At the end of that period, a re-survey is conducted, with the expectation that the agency will at least score high enough to give them a one-year certificate. However, should the agency score less than 80 on the re-survey, the certification unit may recommend a second provisional status, which also may not exceed 60 days in length. A follow-up re-survey is conducted at the end of the second provisional period, and if the provider does not score at least an 80, a recommendation is forwarded to the Commissioner of the DMH to de-certify the provider agency.

In addition to the routine certification surveys, the Operating agency may also conduct for cause surveys, in response to concerns or complaints about treatment and care of participants. Frequently the result of a for-cause survey is that the agency gets put on provisional certification and is required to submit and implement a plan of correction.

During a process in which a provider agency is in provisional status, the Regional Offices and Advocacy Section of the operating agency provide increased monitoring and technical assistance. This is both to assure basic health and welfare of the individuals receiving services and to assist the provider agency in coming into compliance.

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)*
	☑ *State Medicaid Agency*	☑ *Weekly*

State:	
Effective Date	

	X Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*X Quarterly*
	☐ Other: Specify:	*☐ Annually*
		☐ Continuously and Ongoing
		☐ 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 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.

State:	
Effective Date	

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

☐	**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; and, (f) how participants are notified of the amount of the limit.

☐	**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.*
X	**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.*
	With approval of the 1115 demonstration waiver ("Community First") that will operate concurrently with this waiver, four enrollment groups with distinct funding levels will be established within this waiver: 1. Children with ID, ages 3-13, that are living with family or other natural supports. 2. Transition-age youth with ID, ages 14-21, who are living with family or other natural supports, or living independently (18-21). 3. Working-age and older adults with ID, ages 22+, who are living with family or other natural supports, living independently or able to live in a non-intensive supported living arrangement. 4. Individuals 3+ with ID who are not able to live with family or other natural supports, living independently or able to live in a non-intensive supported living arrangement. Enrollment groups are based on age of the waiver participant and living situation. Each enrollment group has access to a unique sub-set of services from among those detailed in Appendix C-3. Through public comment held in July, 2019 on a "concept paper" that was a first iteration of the

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new Community Waiver program that includes this waiver, the 1115 demonstration waiver that is proposed to operate concurrently with this waiver, and the 1915i SPA that is also proposed to operate concurrently with the 1115 waiver, the proposed range of services available for each enrollment was shared publicly and stakeholder feedback was used to finalize the services available to each enrollment group. Services are specifically tailored to the age group and living situation of each enrollment group, taking account of services available through other programs depending on age (e.g. EPSDT; Public School System/Special Education; Vocational Rehabilitation). Each enrollment group will also have its own expenditure cap, based on historical utilization of similar services by individuals with ID served by ADMH/DDD in similar age range and living situation. The expenditure cap for each enrollment group has also been informed by the experience of an adjoining state operating a very similar HCBS program for IDD population and their budgeted costs after 2.5 years of program experience and with over 2,700 individuals enrolled. The expenditure cap for each enrollment group applies to all services, except Minor Home Modifications if available in that enrollment group. Expenditure caps will be monitored and adjusted, as needed, based on patterns of service utilization and expenditures for each enrollment group. On an individual participant basis, there is a provision in policy to allow for an expenditure cap to be exceeded as a cost-effective alternative to transition to an enrollment group with a higher expenditure cap or to prevent institutionalization. If an individual cannot be safely served (addressing health and welfare needs) in the enrollment group in which they are enrolled, with the exception just described, the individual will be transitioned to an enrollment group with a higher expenditure cap. No transition to a separate waiver will need to occur. Waiver participants are notified of the enrollment group which they are being enrolled in when they enter the waiver, and they are notified in writing when they qualify for an exception to the expenditure cap or transition to an enrollment group with a higher expenditure cap. The services available by enrollment group are detailed below:

Program Enrollment Groups	1915c Group #1	1915c Group #2	1915c Group #3	1915c Group #4
Age Range	**3-13**	**14-21**	**22+**	**3-No Limit**
SERVICES AND SUPPORTS				
Support Coordination	X	X	X	X
Individual Employment Exploration*		X	X	X
Individual Employment Discovery*		X	X	X
Individual Employment Job Development Plan*		X	X	X
Individual Employment Job Development*		X	X	X
Individual Employment Job Coaching*		X	X	X
Individual Employment Co-Worker Supports		X	X	X
Individual Employment Career Advancement*			X	X
Small Group Supported Employment		X	X	X

Integrated Employment Path Services		X	X	X
Financial Literacy and Work Incentives Counseling	X	X	X	X
Community Transportation*	X	X	X	X
Independent Living Skills*	X	X	X	
Personal Assistance Home*	X	X	X	
Community Integration Connections and Skills Training*			X	X
Personal Assistance Community*	X	X	X	X
Peer Specialist Services			X	X
Family Empowerment and Systems Navigation Counseling	X	X	X	
Natural Support or Caregiver Education and Training	X	X	X	
Counseling on Alternatives to Full Guardianship		X	X	
Breaks and Opportunities (Respite)*	X	X	X	
Assistive Technology and Adaptive Aids	X	X	X	X
Remote Supports		X	X	X
Housing Counseling Services		X	X	
Housing Start-Up Assistance		X	X	
Minor Home Modifications (not included in expenditure cap)	X	X	X	
Supported Living Services			X	X
Adult Family Home				X
Community-Based Residential Services				X
Individual Directed Goods and Services*	X	X	X	X
Positive Behavior Supports	X	X	X	X
Physical Therapy		X	X	X
Occupational Therapy		X	X	X
Speech and Language Therapy		X	X	X
Skilled Nursing*		X	X	

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

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Appendix 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, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

For most services offered in this waiver, the settings where they will be delivered are a person's own home or family home, or integrated community settings including competitive integrated employment settings and other integrated community settings outside the home that are not disability-specific settings or provider owned or controlled settings. In these settings, the individual's experience will be monitored on an ongoing basis by the Support Coordinator to ensure their experience is consistent with the HCBS Settings Rule requirements.

Settings that will be used in this program that are HCBS Settings that were approved for and used for HCBS prior to March 17, 2014 are addressed in Attachment #2 (Home and Community-Based Settings Waiver Transition Plan) of this application.

New settings that are disability-specific or provider owned or controlled (including small group Supported Employment settings) that will be used to deliver services in this waiver will go through certification by ADMH/DDD to ensure they fully comply with HCBS Settings Rule requirements. Prior to a waiver participant receiving services in this setting, the provider operating this setting will need to submit all relevant policies and procedures for "Pre-Service Certification" by ADMH/DDD. Subsequently, ninety (90) days after the first waiver participant(s) begins receiving services funded by this waiver in the setting, the Support Coordinator(s) will complete an Individual Experience Assessment with each individual to ensure their experience is consistent with the HCBS Settings Rule requirements and the provider's approved policies and procedures. Any issues will be addressed immediately through a corrective action plan that will be monitored by ADMH/DDD for timely completion. If no issues (or when identified issues resolved), the settings will receive a "Full Certification" for HCBS Settings Rule compliance and then will be subject to ongoing monitoring by ADMH/DDD Regional Office Monitors, as described in the Statewide Transition Plan.

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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 *(check 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)
X	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
	Support Coordinator (qualifications not specified in Appendix C-1/C-3) A four-year college degree in a human service-related field and twenty-four months or more of experience working with vulnerable populations.
☐	**Social Worker** *Specify qualifications:*
X	**Other** *Specify the individuals and their qualifications:*
	The individual's team, composed of the individual, legal representative if applicable, family & friends as appropriate, support coordinator, and all other persons providing services and support to the individual, is responsible for development of the person-centered plan. It is important that people are present that know the individual very well. Note: wherever reference is made to the individual in Appendix D, the legal representative is also included, if the individual has a legal representative.

b. Service Plan Development Safeguards.

Select one:

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

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☐	**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*:

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.

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant. In order to ensure conflict free support coordination, the state is employing Support Coordination staff to develop person centered plans. Additionally, the Support Coordinator may meet with the individual without contracted providers present in order to allow an opportunity for the individual to speak freely about their providers and/or to request to change the provider for one or more services in their plan.

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):

a. The development of the PCP is driven by the individual, and with support and guidance from the Support Coordinator, as well as the support of other people of the individual's choosing. The Support Coordinator facilitates the person-centered planning process to the extent necessary to ensure a high-quality process and also facilitates the completion of the paperwork and data entry relative to the completion of the PCP.

The individual and the Support Coordinator develop the initial PCP during the first 60 days of enrollment. Any service needs related to health and safety will be identified early and will be addressed through interim PCP and plan of care put in place within 14 days of enrollment, that will also include authorization of Support Coordination. At minimum, the

individual and the Support Coordinator formally review and update the PCP annually. The individual and the Support Coordinator must also formally review and update the PCP when a change in the goals, needs related to goals, availability of services and supports through other systems or programs, or condition of the individual occurs. During every required face-to-face visit (monthly for first year of enrollment and then quarterly thereafter) and every required monthly phone contact, the Support Coordinator and individual informally review the PCP, progress on goals, effectiveness of services, and current satisfaction of the individual. In all situations, formal or informal, when a change in the goals, needs related to goals, availability of services and supports through other systems or programs, or condition of the individual occurs, the Support Coordinator is responsible to assist the individual in updating the PCP. Information discussed in a person-centered planning meeting is communicated and explained to the person in a method he/she is most able to understand, and also communicated and explained to the legal representative (if applicable), both at and prior to the scheduled meeting; however prior discussion may not be possible in the event an emergency meeting is necessary.

b. The individual and the Support Coordinator have several person-centered planning tools and assessments available to them to be used to help identify the individual's goals, needs related to these goals, to identify generic and other system resources available to address these needs and goals, and to determine which waiver services and supports are available that best meet these goals and needs, as well as the appropriate quantities of the identified waiver services and supports.

- An assessment that results in an accurate and complete picture of the person's current situation, what is important to and for the person supported, and t identification of the individual's goals in various life domains (e.g., home, work, relationships, community membership, health and wellness), including changes the person desires in his/her life as well as things the person wishes to remain the same.

- An assessment that considered needs related to achieving or sustaining the goals identified by the individual, including identification of services and supports available from sources other than the waiver, as well as supports and services available from the waiver, that together best address these needs,

- The identification of individual risk factors, and identification of strategies to mitigate the negative aspects of these risks, including documentation of the individual's understanding of the risks (both benefits and potential negative implications) including the proposed mitigation strategies, with documentation that those strategies have been clearly explained as part of the individual making an informed decision about each identified risk;

- An assessment of the individual's current adaptive functioning s through the administration of a uniform assessment instrument (such as Inventory for Client and Agency Planning (ICAP));

- Additional assessments, where appropriate, by health care or other relevant professionals (e.g., occupational or physical therapists, assistive technology consultants, behavior analysts, etc.);

- The Home and Community Support (HCS) Assessment helps quantify the amount of personal assistance services needed by the individual to meet their needs

At least annually, an assessment of the individual's experience to confirm that that the settings in which the individual is receiving services and supports comport with standards applicable to HCBS Settings delivered under Section 1915(c) of the Social Security Act. This includes those requirements applicable to provider-owned or controlled settings if applicable, and except as supported by the individual's specific assessed health and/or safety need(s) and documented in the person-centered plan in accordance with federal regulatory requirements for such modifications.

c. From the person-centered planning process, informed by the assessments above, the individual and the SC identifies supports and services to address the identified individual's desired goals and outcomes. The individual and Support Coordinator first explore unpaid and natural supports, then supports and services from other systems and programs available to the individual, followed by services and support funded by the waiver program, utilizing waiver funding as the funding source of last resort. When considering waiver services, the Support Coordinator is required to assist the individual in evaluating the waiver services and supports that will most effectively meet the individual's desired goals, outcomes and needs. As a written resource, the individual has access to the document, "Waiver Service Definition Manual" which defines each service available in the waiver program, the types of goals, outcomes and needs each service is designed to address, and the requirements for provider qualifications. Support Coordinators are trained to be skilled in explaining services and supports, including those available through generic community resources and other systems and programs.

d. Support Coordinators are required to document the individual's goals/outcomes, needs and preferences that are identified through a collaborative review of the aforementioned tools and exploratory discussion involving the individual's person-centered planning team. Prior to concluding the PCP development process, Support Coordinators must review their documentation of all of the planning conversations with the individual to ensure the PCP meets all of the person's identified needs and preferences related to their identified goals and outcomes.

When an individual chooses not to address one of their needs or preferences on the PCP, the Support Coordinator discusses this choice with the individual. If the individual elects to not address an identified need or preference through the waiver PCP, this conversation must be documented, including the Support Coordinator's effort to encourage the

individual to address the need. In cases wherein the unaddressed need is related to health and safety or presents another type of risk, the Support Coordinator completes the document, "Risk Agreement – Waiver Program" with the individual to document information and resources provided to the individual. Support Coordination Supervisors (SCS) are required to ensure that the PCPs developed by their Support Coordinators meet the needs of the individual as required by this waiver and waiver program policy and work instructions. DDD Regional Office Staff conducts record reviews that evaluate a sample of individual PCPs to ensure that the PCPs adequately meet the individual's needs related to their identified goals and outcomes. SCSs and/or DDD Regional Office Staff will be required to remediate any individual negative findings as well as require a corrective action plan (CAP) to improve insufficient performance if a trend is found with a particular Support Coordinator.

e. When the individual and Support Coordinator have identified waiver services and supports to meet the individual's needs related to the individual's goals and outcomes, the individual determines whether they wish to use self-direction (if applicable for services selected) , agency providers, or a combination of self-direction for some services in the PCP and agency providers for other services.
For each need that waivers services will address, the PCP must describe the specific service or support which will meet that need, including how much, who will provide it, and when/how often it will be provided. SCs are responsible for coordinating all supports and services in the PCP and working closely with those identified in the PCP as providing specific services and supports. The SC is also responsible for monitoring the provision of those supports and services through routine monitoring visits, regular communication with the individual, and review of written documentation submitted by the providers.

f. Ongoing monitoring by the SC is accomplished through monthly face-to-face monitoring visits during the first year of enrollment and a minimum of quarterly face-to-face visits after the first year of enrollment. Face-to-face visits should be coordinated with the person supported (and their family or involved friend/ally, as applicable) and should generally occur in the person's residence at least once per quarter. However, if requested by the person (or their family or involved friend/ally, as applicable), visits can be scheduled at alternative locations that are convenient for the person (and their family or other involved friend/ally as applicable), unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted atin the person's home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request which shall be documented in the PCP or based on a significant change in needs or circumstances. Completion of a monthly status

review of the PCP will be documented for each individual per service received and across service settings.

g. Person Centered Plans are subject to continuous revision, as needed. However, at a minimum, the PCP is reviewed by the Individual and SC during a formal review at least annually. During this time, the individual's progress on the goals and outcomes identified on the previous year's PCP is reviewed as a priority. The individual and Support Coordinator collaborate to ensure the new PCP is an accurate and current reflection of the individual's goals/outcomes and needs related to these goals/outcomes, and that the PCP adequately supports the individual's goals and outcomes with waiver–funded services used to wrap around generic community services and supports and services and supports available through other programs and systems.. When the cost of an individual's needs exceed the person's expenditure cap, the Support Coordinators is required to involve his/her Supervisor to review the PCP and assist the individual, as needed, in completing documentation for approval to exceed the expenditure cap (or receive approval for a one-time emergency expense) to avoid enrollment in an enrollment group with a higher expenditure cap, particularly to avoid residential placement if the person is living with natural supports or living independently.

Through the SC's monthly and quarterly contacts, the SC will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring for the individual and being effectively addressed by the person's providers of waiver services and supports.

It is also the SC's responsibility to review the provider's submitted documentation at least monthly, and note any problems, concerns, discrepancies, dramatic changes or other occurrences that would indicate a need for review of the provider's performance or the individual's goals/outcomes or needs. The SC's review of the provider documentation will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk and/or if services are not being delivered according to the PCP.

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.

A risk assessment is administered as part of the process for developing the person's PCP. The assessment process is intended to create an environment that establishes appropriate safeguards for the person without limiting personal experiences and growth opportunities. A person-centered approach is employed to identify risk factors, to identify the potential benefits of the individual taking certain risks (e.g. opportunities for learning, personal growth, independence, community involvement, etc. that otherwise would not be available to the individual), and to develop proactive strategies to mitigate the potential negative consequences of the identified risks. Based on the life the person desires to lead, the assessment identifies potential situational, environmental, medical, financial and other relevant risks. When risks are identified, the strategies necessary to address and mitigate them, while still enabling a person to achieve his/her desired goals/outcomes, lifestyle and routines, are incorporated into the PCP.

Each individual should have an emergency preparedness plan, should be trained on this plan, and practice implementing their plan on a regular basis. People are supported to become knowledgeable about how to access emergency medical care when needed. Medication ordered by a physician to use in a potential emergency is available in the appropriate dose, quantity and form. Whenever possible and as a first consideration, strategies will identify informal (unpaid) supports that could assist in meeting emergency needs. The individual can select from provider organizations that have emergency plans to deal with a variety of situations and accommodate the individual needs of people supported, and that ensure emergency contact numbers are readily available and accessible to their staff, volunteers and people receiving supports.

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.

Individuals in this waiver have choice from among the qualified providers (with an active provider agreement with ADMH/DDD) available for the specific services and supports for which they have an assessed need, related to a specific desired goal/outcome that cannot be met by natural supports or other generic resources or programs available to the individual. At least two providers are available for each specific service or support, from which an individual may choose, or the individual may opt to self-direct and hire their own workers with assistance from a Financial Management Service. All available providers also offer services in a choice of settings that are integrated in, and support full access 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. The state ensures that each individual found eligible for the waiver is given choice among the qualified providers in their area for each service included in his/her PCP. The SC will provide information about qualified providers and will undertake other steps to facilitate informed choice by the waiver participant.

A Due Process Rights Form is presented to each waiver participant (and his/her family/involved friend) as part of the planning process, and each individual and/or legal representative must sign, acknowledging receipt of the information regarding his/her right to a hearing.

The individual's signature on the Free-Choice of Qualified and Contracted Providers form, and on the plan of care, combined with the information presented in the Due Process Rights Form, assures the person is aware of his/her rights including choice of providers.

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 Interagency Memorandum of Understanding between the Alabama Medicaid Agency and the Alabama Department of Mental Health outlines the authority given to the Department of Mental Health to approve and sign-off on the Plan of Care including the initial POC as well as annual updates to the POC. This will also include any other instances where there is a substantial change in the Plan of Care. Below are the ways that Medicaid and DDD ensure that the requirements are met for Personal Centered Planning and Service Delivery as well as Service Plan Development:

1. The Support Coordinator monitors/reviews services, and does so on a quarterly basis at a minimum.
2. The Regional DMH Office provides a 6 month minimum visit/review to each service site and a semi-annual random review of the Support Coordinator records.
3. The DMH Programmatic Certification offices have monitoring of the person centered plan responsibility.
4. Other monitoring and technical assistance reviews are completed by DMH Advocacy office and DMH Quality Enhancement office.
5. Medicaid nurses conduct a scientifically calculated random record review each month of all plans of care for persons initially enrolled or re-determined for waiver services during the previous month. These records are made available through the Support Coordinator and/or the Regional Community Services Office.

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**
X	**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**
X	**Operating agency**
☐	**Case manager**
☐	**Other** *Specify:*

Appendix 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.

(a) Support Coordinators (SC) assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by SCs is essential and they have primary responsibility for determining if services are being implemented as specified in the PCP and if the services described in the plan are meeting the person's needs and assisting the person to achieve his/her desired goals and outcomes. In addition, Medicaid Quality Assurance staff also play a role in monitoring plan of care implementation as described in (b).

(b) Ongoing monitoring by the SC is accomplished through monthly face-to-face monitoring visits during the first year of enrollment and a minimum of quarterly face-to-face visits after the first year of enrollment. Face-to-face visits should be coordinated with the person supported (and their family or involved friend/ally, as applicable) and should generally occur in the person's residence. However, if requested by the person (or their family or involved friend/ally, as applicable), visits can be scheduled at alternative locations that are convenient for the person (and their family or other involved friend/ally as applicable), unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted at the person's home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request which shall be documented in the PCP, or based on a significant change in needs or circumstances.

(c) Completion of a monthly status review of the PCP will be documented for each individual per service received and across service settings. Information is gathered using standardized processes and tools. The SC reports identified issues, including any issues related to risk identification and management, to management staff from the involved provider agencies or self-direction workers as applicable. DDD SC Supervisors may assist in achieving resolution when timely provider or self-direction worker response does not occur.

Monitoring of risk management is accomplished through ongoing evaluation of the effectiveness of risk identification and mitigation strategies. The success of individual strategies to mitigate specific, identified are evaluated by the person supported, their families and significant others, providers, and the SC as part of on-going planning for and monitoring of services. In addition, the SC conducts initial (if a setting where services delivered is new)) and at least annual assessment of the individual's experience, in accordance with timeframes outlined in State Protocol, to confirm that that the settings in which the person is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act,

including those requirements applicable to provider-owned or controlled settings, except as supported by the individual's specific assessed health and/or safety need(s) and documented in the person-centered plan in accordance with federal regulatory requirements for such modifications

Medicaid Quality Assurance staff annually perform a separate review of a random sample of plans of care and related documents for the individuals served by each provider, to assure the individuals receiving services under the waiver, from the specific provider, have a plan of care in effect for the period of time the services were provided. This review also ensures that the need for the services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

b. Monitoring Safeguards. *Select one:*

X	**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*:

The state is limiting Support Coordination to employees of the Division of Developmental Disabilities. As such, this ensures conflict-free case management because employees of the Division may not also function as contracted providers of any waiver services for waivers operated by the Division.

The SC monitors both the implementation of the plan and the individual's health and welfare as part of On an on-going basis, the SC Supervisor will pull a sample of waiver individual's PCPs to ensure compliance with the waiver which includes reviewing staffing patterns, ensuring individual emergency plans are being followed, and incidents are being reported. If there is an instance where staffing is inconsistent with the individual plan the SC Supervisor's monitoring report will summarize the findings, including notation if a plan of action is needed, if so when is it needed and what it is to cover, and notation of planned follow-up by the SC if needed, and when and how (in person, letter or telephone). The SC Supervisor may also request that an incident report be submitted for further review. If it is determined that the lack of staffing or emergency plan implementation puts the individual at risk of harm to self or others then a "for cause review" by Certification staff can be requested by the SC Supervisor.

The DMH Regional Community Services Waiver Coordinator reviews individual's plans throughout the year to ensure the Operating Agency is meeting the required quality indicators as approved in the waiver document. Additionally, the Operating Agency's Certification personnel reviews a sample of individuals' person-centered-plans as part of the site review. The Certification staff reviews a sample of individual records, including the PCP and incident records, as a component of the comprehensive provider certification process. This also includes review of a sample of individual records to ensure the individualized

	emergency plans are developed for everyone and address a variety of situations based on the person, as well as ways to accommodate the individual needs of that person. This falls under the Best Possible Health certification domain. Best Possible Health requires 100% compliance in order to receive a certificate to provide services. If this section is not passed with 100% then the provider will be placed on "Provisional" status and a plan of correction must be submitted and implemented. Once the plan of correction is approved the provider will receive a one-year certification. Finally, if a complaint or request for review is made to the ADMH Internal Rights Protection and Advocacy Program, and inadequate staffing or lack of implementation of an emergency plan is noted, then the DDD will be asked to investigate and address any issues identified.

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**

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.

i. 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 consumer participant service plans that address personal goals. Percentage = NUMERATOR [number of participants who have personal goals addressed in the service plan through waiver funded services or other funding

State:	
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	sources or natural supports] / DENOMINATOR [Number of participants reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*
If 'Other' is selected, specify:
Participant Assessment Form and person centered service plan (PCCP)

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of participant service plans that address all participant's assessed needs, including health and safety risk factors.

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	Percentage = NUMERATOR [Number of participant service plans that address all participant's assessed needs, including health and safety risk factors] / DENOMINATOR [Number of participants]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant Assessment Form and Person Centered Service Plan	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

State:	
Effective Date	

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

i. 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.

Add another Performance measure (button to prompt another performance measure)

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

i. 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 participants whose needs changed and whose service plans were revised accordingly. Percentage = NUMERATOR [Number of participants reviewed whose needs changed and whose service plans were revised accordingly] / DENOMINATOR [Number of participants reviewed whose needs changed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Person centered service plan (PCCP)	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*

State:	
Effective Date	

	X Operating Agency	☐ Monthly	X Less than 100% Review
	☐ Sub-State Entity	☐ Quarterly	X Representative Sample; Confidence Interval =95
	☐ Other Specify:	X Annually	+/-5%
		☐ Continuously and Ongoing	☐ Stratified: Describe Group:
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	X Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver Percentage = NUMERATOR [Number of participants reviewed whose service plans were reviewed with the participant according to the timeframes specified in the waiver] / DENOMINATOR [Number of participants reviewed Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Person Centered Service Plan	

	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)*

State:	
Effective Date	

	X State Medicaid Agency	☐ Weekly	X 100% Review
	X Operating Agency	☐ Monthly	X Less than 100% Review
	☐ Sub-State Entity	☐ Quarterly	X Representative Sample; Confidence Interval =95
	☐ Other Specify:	X Annually	+/- 5%
		X Continuously and Ongoing	☐ Stratified: Describe Group:
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ Weekly
X Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	X Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.

i. 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.

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Performance Measure:	Number and percent of waiver individuals that receive services and supports in the amount specified in the service plan. Percentage = NUMERATOR [Number of waiver individuals that receive services and supports in the amount specified in the service plan] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant record review; Claims	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/-5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of waiver individuals that receive services and supports in the duration specified in the service plan. Percentage = NUMERATOR [Number of waiver individuals that receive services and supports in the duration specified in the service plan] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant record review; Claims	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/-5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of waiver individuals that receive services and supports in the frequency specified in the service plan. Percentage = NUMERATOR [Number of waiver individuals that receive services and supports in the scope/frequency specified in the service plan] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant record review; Claims	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/-5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of waiver individuals that receive services and supports in the type specified in the service plan. Percentage = NUMERATOR [Number of waiver individuals that receive services and supports in the type specified in the service plan] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Participant record review; Claims	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/-5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Add another Performance measure (button to prompt another performance measure)

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

i. 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 participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services and providers. Percentage = NUMERATOR [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services and providers] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Freedom of choice form	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	

State:	
Effective Date	

				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of individuals offered a choice between/among service and providers. Percentage = NUMERATOR [Number of individuals offered a choice between/among services and providers] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Freedom of choice form	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	

State:	
Effective Date	

				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of service plans that document the waiver individual was offered and made a choice between traditional and self-directed care. Percentage = NUMERATOR [Number of service plans that document the waiver individual was offered and made a choice between traditional and self-directed care] / DENOMINATOR [Number of participants reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Freedom of choice form	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
■	*X Operating Agency*	*☐ Monthly*	*X Less than 100% Review*
■	*☐ Sub-State Entity*	*☐ Quarterly*	■ *X Representative Sample; Confidence Interval =95*
■	*☐ Other Specify:*	*X Annually*	■ *+/- 5%*
		☐ Continuously and Ongoing	■ *☐ Stratified: Describe Group:*
		☐ Other Specify:	■

State:	
Effective Date	

				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of participants that answered "yes, all services" or "sometimes, or some services" to being able to choose or change what kind of services they received. Percentage = NUMERATOR [Number of participants that answered "yes, all services" or "sometimes, or some services" to being able to choose or change what kind of services they received] / DENOMINATOR [Total number of survey respondents]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
NCI-AD and NCI Survey	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*

State:	
Effective Date	

		☐ Other Specify:		
				X Other Specify:
				Sample size deemed appropriate by NCI.

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	X Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.*

Remediation of individual problems occurs when problems are discovered by the regional office in monitoring plans. All of the discovery measures previously listed are produced by this monitoring, and the report of monitoring also includes notation of follow-up actions needed. The measures of remediation actions needed and performed are included in the electronic aggregation and reporting system, and are listed below:

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Remediation: Measure 1
The number and percent of reviews which required individual technical assistance.

Remediation: Measure 2
The number and percent of reviews which required agency wide technical assistance and training.

Remediation: Measure 3
The number and percent of reviews which required a Plan of Correction.

If there are any reviews which required a plan of correction but the plan was either not submitted, not acceptable or not implemented, follow-up action would consist of referral to a "for-cause" certification review. In addition, depending on what the specific deficits were, funding could be recouped.

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):*
	☐ **State Medicaid Agency**	☐ **Weekly**
	X Operating Agency	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		X Continuously and Ongoing
		☐ **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 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.

State:	
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State:	
Effective Date	

Appendix E: Participant Direction of Services

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

X	**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-1: Overview

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.

a) Participants in the waiver will be offered an opportunity to self-direct services as the common law employer of record with service-specific budgetary authority. Once a participant's comprehensive assessment and PCP process has been completed, and needed waiver services are identified, the participant may select the specific services they wish to self-direct from the list of services that can be self-directed. The participant may also receive some of the services in their PCP through traditional supports and services from a provider agency, consistent with the plan of care and ensuring no services are duplicative. Services that can be self-directed include: Personal Assistance-Home, Personal Assistance-Community, Community Transportation, Breaks and Opportunities (Respite), Employment Supports—Individual Employment Support (Exploration, Discovery, Job Development Plan, Job Development, Job Coaching, Career Advancement), Community Integration Connections and Skills Training, Independent Living Skills Training, and Skilled Nursing.

b) Each participant may choose to select self-directed services, and/or request more information about the option to self-direct services at any time. Self-Directed services is shared as an option upon enrollment and no less than during the initial and each subsequent annual person-centered planning meeting. The Support Coordinator (SC) and as needed the Support Coordination Supervisor will be able to answer questions about the self-directed services option and provide an SDS Handbook to the participant and his/her legal representative, family or involved friend.

c) The SC will complete an assessment to determine the supports needed for a participant (or his/her family/legal guardian/involved friend, on behalf of the individual) to self-direct services, and assist in the completion of the employer paperwork to send to the FMSA for initial set up. A fiscal intermediary (Financial Management Service Agency or FMSA) will be available for each participant who chooses to self-direct services. The FMSA will provide an orientation for any participant choosing to self-direct. The FMSA will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing. The FMSA will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance. The FMSA will assure the participant's employee(s) (the self-direction workers) complete all required training in the timeframes required, including training on how to identify and report critical incidents and report incidents. All incidents should be reported to the support coordinator and Regional Office. The same follow-up procedures found in Appendix G.

The FMSA will process payments to self-direction workers. The FMSA will be paid as an administrative cost In addition to the services of the FMSA, participants who self-direct will have a SC trained in self-direction and the services available for self-direction. The SC will be able to inform and consult, intervene, and trouble shoot any problems the participant may have that cannot be addressed by the FMSA. The Support Coordinator will provide an overview to the person (and families/legal guardian/involved friend as applicable) on how to identify and report critical incidents and report incidents. All incidents should be reported to the support coordinator and Regional Office. The same follow-up procedures apply as is found in Appendix G.

Participants who select self-direction will have a budget for each service in the plan of care, developed during the person-centered planning process, that they choose to self-direct. Units of service will be authorized, based on assessed need, and those units will then be converted into a dollar amount that the participant can use to hire their own staff to provide the identified service in the amount specified in the plan of care

If funds are saved through wage negotiations, these will be placed into a savings account managed by the FMSA. A savings plan will be developed through the person-centered planning process identifying items or additional needed services, otherwise coverable under the waiver (including through Individual Self-Directed Goods and Services), that are intended for purchase using the savings account. This savings plan can be revised as participant needs change. The participant/family/legal representative/involved friend (who wil lreceive an SDS Handbook) will manage their self-direction workers and the services they deliver (with the assistance of the FMSA and support coordinator) by setting the employee pay rate, covering the cost of overtime pay (if applicable), purchasing worker's compensation insurance, and managing/utilizing the savings account.

Individual Directed Goods and Services can be accessed with accompanying self-directed waiver services and procured through the participant's savings account maintained by the FMSA. The spending plan developed will list the items the participant intends to save for and purchase and must be approved by the Support Coordination Supervisor. The reimbursement or purchase of goods and services on behalf of the waiver participant will be made through the FMSA. When reimbursing the participant directly, a valid receipt(s) will be needed. If the participant cannot pay for the good or service up front, then the FMSA will work out a process to procure a receipt and

State:	
Effective Date	

pay the vendor in advance. A copy of the valid receipt will be sent, by the FMSA, to the Support Coordinator to ensure the good or service was rendered or received.

Utilization will be reviewed routinely to ensure authorized dollars are being appropriately allocated and expended, to ensure the health, safety, and welfare of the participant, and to ensure the goals and outcomes identified in the PCP are being effectively addressed. Under-utilization of dollars will be reviewed on an individual basis. Budgets will be reviewed annually and adjusted up or down based on prior-year utilization and a current assessment of needs.

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.
X	**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.**
X	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:
	Participant direction opportunities are available to any wavier participants who are willing, who have the support to self-direct if needed, and who have one or more services that can be self-directed included in their PCP and plan of care.

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.**
X	**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*
	Participants can choose to self-direct some of the services as identified in Appendix E-1 g.

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.

a) Information about opportunities for self-directed services (SDS) (e.g. describing benefits, responsibilities and liabilities, together with an overview of the FMSA role, the Support Coordinator's role, and the overall process) is available in a SDS handbook. As part of the comprehensive assessment and person–centered planning process, the SC is required to explain that SDS is an option, participation is voluntary,, the choices that are available within SDS, the supports and resources that are available to assist individuals with SDS, and an overview of the situations which may limit or terminate SDS for a member. Led by the SC, the individual and his/her team must also address which specific services the individual chooses to self-direct, what level of participation the individual chooses to exercise, whether the individual will need assistance or support to participate in SDS, resources (including natural supports) available to assist members participate in SDS, whether any potential health or safety issues exist related to SDS and how to address them, and the extent to which the member has chosen to participate in the negotiation regarding payments for services, the manner in which payroll and benefits will be

administered, and the need for training legal decision makers and/or self-advocacy training for the individual. The team must also ensure mechanisms are in place to ensure the individual's expenditures are consistent with their approved budget, identify any changes needed to the individual's budget or related supports, exercise oversight over potential health and safety issues, exercise oversight regarding potential conflicts of interest, and participate with the FMSA in validating self-direction workers complete required direct service professional training. Annually, individuals must also affirm the SC explained the SDS option to them and affirmatively accept or deny the SDS option by choosing the appropriate option on their person-centered plan.

b) Information about SDS is provided by the SC.

c) The handbook will be provided to support coordinators to take with them to all planning meetings, so that they may reference and share information with individuals and team members. If an individual requests information about SDS at another time, then the SC will provide a copy of the handbook within 10 business days and schedule a discussion with the individual to be completed within 15 business days. Additional information is provided to individuals on an ongoing basis throughout the person-centered planning process.

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.**
X	**The state provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:

X	**Waiver services may be directed by a legal representative of the participant.**
X	**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:

Representative may include a legal guardian or family member with whom the participant lives. A legal guardian or family member serving as a representative may not also be paid through self-direction to provide Personal Assistance-Home or any other waiver service. A representative must be able to assure the Regional Office that he or she has no conflict of interest and will support the individual's best interests. Second, there must be evidence that he or she is competent, willing and able to fulfill all the responsibilities, including providing sufficiently close supervision to a) assure the participant's health and welfare and b) sign the worker's timesheets with assurance each timesheet is accurate and truthful. Third, the representative must be chosen by the participant, but the representative cannot be paid for being a representative nor to provide any other waiver service to the participant. In cases where the person chosen by the participant as the representative may raise concerns of the Regional Office, a background check can be requested prior to final approval of the representative.

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. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Assistance-Home	X	X
Personal Assistance-Community	X	X
Community Transportation	X	X
Breaks and Opportunities (Respite)	X	X
Employment Supports—Individual Employment Support (Exploration; Discovery; Job Development Plan; Job Development; Job Coaching; Career Advancement)	X	X
Community Integration Connections and Skills Training	X	X
Independent Living Skills Training	X	X
Individual Directed Goods and Services		
Skilled Nursing		

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.*

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

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☐	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**
X	**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 first Financial Management Service Agency (FMSA) was originally procured through a competitive RFP issued by the Alabama Department of Mental Health to administer Alabama's other 1915c waiver programs. The vendor organization which was originally awarded the contract demonstrated clear superiority of experience and capabilities. Based on experience, cost, and references, the Department of Mental Health has now selected two vendors to provide the FMS services. Each contract is set for two years then the RFP process has to be completed again.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

PMPM cost for FMS services is based on the number of participants enrolled.

The payments for the services provided by the FMSA will be based on an invoice submitted monthly. Payments are calculated according to a per-participant-per-month fee schedule. The fee is for a variety of activities specified in the vendor contract, and the fee is the same for every participant for whom an activity is provided during the month.

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:

X	**Assists participant in verifying support worker citizenship status**
X	**Collects and processes timesheets of support workers**
X	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐	**Other** *Specify:*

The FMSA will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing.

The FMSA will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance.

The FMSA will procure goods and/or services on behalf of the participant.

		The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis. The FMS will also report budget balances to the regional office, support coordinator, and individual or his/her representative. The FMS will conduct monthly checks to ensure no worker(s) currently employed by a waiver participant has been debarred. (Medicaid website and OIG website). The FMSA furnishes background checks on prospective employees and representatives if requested. The FMSA assures prospective employees meet waiver requirements, including training requirements for the specific service(s) they are providing. The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.
	Supports furnished when the participant exercises budget authority:	
	X	**Maintains a separate account for each participant's participant-directed budget**
	X	**Tracks and reports participant funds, disbursements and the balance of participant funds**
	X	**Processes and pays invoices for goods and services approved in the service plan**
	X	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	□	**Other services and supports** *Specify*:
	Additional functions/activities:	
	X	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	X	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	X	**Provides 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 FMSA will provide reports and documentation to the Regional Office, Support Coordinator, and the self-directing participants as requested. The reimbursement to the FMSA will be based on the timecard submissions. If there has been an error in timecard submissions, then the error will be corrected by the following pay period. The Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood. The Support Coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the Support Coordinator and Supervisor. Receipts for items paid for up front by the FMSA will be reconciled.

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:*	
	The individual's team led by the Support Coordinator is responsible to identify the goals/outcomes and related assessed needs of each individual who selects self-direction. The Support Coordinator is an essential link to waiver participants and families/legal representatives/involved friends who are interested in self-directing services. The Support Coordinator has the Self-Directed Services Handbook that will also be available online. Also included in this is the process for developing the budget for the participant based on the current Person-Centered Plan and plan of care. All these pieces work together to establish a person in self-directing their services.	
□	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the 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**
	(list of services from Appendix C-1/C-3)	Service Coordination
□	**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:*	

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*:
	The Alabama Department of Mental Health operates an advocacy program independent of the Division of Developmental Disabilities (the Operating Agency). This program monitors participants to ensure their rights are not violated and operates a toll-free Advocacy Access Line during normal state business hours and a voice mail response system for after-hour callers for participants to request assistance or report issues. The number

	for this hotline is provided to all participants upon entry to the waiver program and will also be included with the brochure and manual provided to self-directing participants.

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:

Any participant who is self-directing his or her services may request to discontinue this model at any time by informing the team at his or her person-centered planning review or by contacting the Support Coordinator at any other time. The Support Coordinator will provide the participant with free choice of contracted providers in their area who will take over delivering the services, once selected by the individual. The Support Coordinator will coordinate with the individual and other providers to ensure there will be no lapse in service delivery.

An individual transitioning from self-direction to an alternate service delivery method is not terminated from the waiver program. The individual is changing how he or she obtains his or her waiver services. The circumstances under which a participant chooses to voluntarily terminate his/her use of the self- direction model will always be assessed, first by the Support Coordinator, then as needed, by the Support Coordination Supervisor, Regional Office or ADMH Advocacy Section, as a routine component of trying to improve the service delivery system.

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.

Participants may be discharged involuntarily from self-direction because of:

1. Health or Welfare issues: the participant's and/or the representative's desire to continue self-directing will always be considered primary, but the Support Coordinator, or Regional Office staff will report adverse information to the Operating Agency. If in the considered judgment of the Operating Agency the participant's health or welfare is in jeopardy, for any reason from abuse to change of condition, then the Support Coordinator and the team will educate the participant and/or representative about the potential risk. If the participant and/or representative decides to continue, then he/she will complete and sign a risk agreement; otherwise discharge will be completed.

2. Consistent participant failure to correctly utilize the FMSA services to pay his or her staff, after efforts have been made to provide support and training and have repeatedly failed, will result in termination of self-direction and return to a traditional form of services. Likewise, a participant who consistently discharges staff and ultimately is unable to hire anyone will also be returned to traditional services.

3. Anyone who engages in false approval and reporting of timecards, or in any other way acts to deceive or defraud, will be terminated from self-direction. If the person engaging in the fraud was not the waiver participant, referral will be made to the Medicaid Fraud Unit. If that person was the waiver participant, he or she will be returned to traditional services.

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4. The method of returning a person to traditional services when they are involuntarily terminated from self-direction is the same as the method used when a person is voluntarily terminated. The Support Coordinator will provide the participant with free choice of contracted providers in the area who will take over delivering the services. If a change in the services needed is required, the Support Coordinator will work with the person to update the Person-Centered Plan and plan of care appropriately. If appropriate and desired by the participant, the staff which has been providing the self-directed services may be employed by the new provider agency, but that will depend on the conditions that led to the termination of self-direction. The transfer will be as fast as can be arranged depending on the circumstances: if the transition is prolonged for certain services, alternative services that can meet the individual's needs will be used as a bridge.

5. Participants who are terminated from self-direction are not provided the opportunity for a Medicaid fair hearing, because self-direction is only one method of receiving the services. As long as the participant can be and is transitioned to the same essential set of services and his or her needs are met, no adverse action has occurred.

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	0	46
Year 2	0	68
Year 3	0	90
Year 4 (only appears if applicable based on Item 1-C)	0	132
Year 5 (only appears if applicable based on Item 1-C)	0	152

Appendix E-2: Opportunities for Participant-Direction

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:
X	**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*:

X	**Recruit staff**
X	**Refer staff to agency for hiring (co-employer)**
□	**Select staff from worker registry**
X	**Hire staff (common law employer)**
X	**Verify staff qualifications**
X	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	The FMSA will provide a background check to the participant and/or representative as a component of the administrative service for which it is paid
□	**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. Specify the state's method to conduct background checks if it varies from Appendix C-2-a:**
	Drivers license and proof of appropriate insurance
X	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
X	**Determine staff wages and benefits subject to applicable state limits**
X	**Schedule staff**
X	**Orient and instruct-staff in duties**

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X	**Supervise staff**
X	**Evaluate staff performance**
X	**Verify time worked by staff and approve time sheets**
X	**Discharge staff (common law employer)**
□	**Discharge staff from providing services (co-employer)**
□	**Other** Specify:

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*:

X	**Reallocate funds among services included in the budget**
X	**Determine the amount paid for services within the state's established limits**
□	**Substitute service providers**
X	**Schedule the provision of services**
□	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
X	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
X	**Identify service providers and refer for provider enrollment**
□	**Authorize payment for waiver goods and services**
X	**Review and approve provider invoices for services rendered**
□	Other Specify:

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 self-directed budget will be developed based on authorized units from the individual's plan of care which is based on the PCP. The process for developing the service plan will not be different from that of traditional waiver services. The individual's support team will meet and develop the Person-Centered Plan based on the person's goals/outcomes, and related needs. Based on specified goals/outcomes and related needs for support as captured in the Person-Centered Plan, a service plan will be developed with units of service assigned to each

waiver service. The service plan can include both traditional waiver services and self-directed services. The authorized units for self-directed services will be converted to a dollar amount (using the budget assessment tool) that represents the individual's budget for the year.

The individual will have the ability to hire staff (approved by the FMSA), establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Directed Goods and Services service for items or services needed that meet one or more of the following requirements:

- The item or service will decrease the need for other Medicaid services
- and/or decrease dependency on paid support services; and/or
- The item or service will promote inclusion in the community, including enhancing family involvement; and/or
- The item or service will increase the waiver participant's independence, including improved cognitive, social or behavioral functioning, and development or maintenance of personal, social or physical skills for independence; and/or
- The item or service will increase the waiver participant's health and safety in the home or in his/her community; and/or
- The item or service will increase the waiver participant's ability to continue living in the community and avoid institutionalization.

All purchases must be for items or services that are not illegal or otherwise prohibited by Federal and State statutes and regulations. All purchases can only be made if the participant does not have the funds to purchase the item or service and the item or service is not available at no cost to the participant through another source. All purchases must also be evaluated to ensure cost effectiveness as compared to other available uses of the savings account to meet the person's goals/outcomes and related needs and to assures health, safety, and welfare.

Any dollars saved through wage negotiations can be applied to the Individual Directed Goods and Services service up to $10,000 per year with a required spending plan developed and maintained for each participant.

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.

The individual will be notified of the option to self-direct services during the Person-Centered Planning process. The Person-Centered Plan requires signatures of all members of the support team, including the individual if able, indicating the option to self-direct services has been reviewed and all involved are in agreement regarding whether the individual will self-direct any services in their Plan of Care. The self-directed services budget amount will be determined, and the participant will be informed of the budget amount during the self-direction enrollment meeting with the Support Coordinator. Requests for adjustments to the self-directed services budget will go through the Support Coordinator. Request will be made to and approved by the Regional Office with Operating Agency involvement as determined to be needed by the Regional Office. The Operating Agency will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate, employee

overtime payment, employee bonuses etc. The self-directed budget does not serve as a limit on the amount of waiver services that an individual may receive. Through assessments and the person-centered planning process, the appropriate types and amounts of services will be determined and included in the plan of care. For those services the person chooses to self-direct, the budget will be built based on the participant's assessed need and units authorized in the plan of care. Budget changes will not be approved for purchase of goods and services not pre-authorized.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X ☐	**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:

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:

Safeguards for preventing premature depletion of the individual's budget are multi-layered. The individual's team will review the self-directed services budget during his or her person-centered plan review. Individual Goods and Services will only be authorized if there is enough savings in the individual's budget and there is not a concern of premature depletion. The FMSA will maintain the individual's budget and savings account and will monitor it monthly to ensure it is appropriate for individual to maintain health and safety. Individual balance reports will be generated monthly and submitted to the individual, Support Coordinator and Regional Office for review. If there appears to be either overutilization or underutilization, the participant will be contacted to outline the concerns. If either over utilization or underutilization is an on-going problem, the individual and representative will be consulted and informed of the possibility of involuntary discharge of self-directed services, and a transfer to traditional waiver services will be made.

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.

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 operating agency adversely affects his/her eligibility status or receipt of services. If an applicant is determined not eligible by the operating agency, he or she is provided with notification of the determination, the reason and authority for the determination, and an explanation of the appeal rights and procedures available to the applicant. The formal process of notification and appeal is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. There is an appeal process conducted by the operating agency at the applicant's choice, with the right to further appeal to the Medicaid Agency being explained to the applicant. If an appeal is made to the Medicaid Agency, a hearing officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings. Medicaid legal counsel will be responsible for taking a lead role in the fair hearing process. 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.

Waiver recipients are provided with the necessary information regarding their opportunities to request a fair hearing as part of the planning process, by receiving and signing the Due Process Rights Form. This form contains the information regarding his/her right to a hearing and acknowledges receipt of it.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the person's team 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 operating 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 Department of Mental Health (DMH) will issue a written notice at least 10 days prior to the action to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information

State:	
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required by 42 C.F.R. Section 431, Subpart E. This notification and the Due Process Rights Form referenced above can be obtained from the operating agency.

The organization has a mechanism that provides people supported and their legally authorized representatives with information regarding filing complaints and grievances. At a minimum, the complaints/grievance procedures include the name and telephone number of a designated local contact within the organization.

The designated local contact has the knowledge to inform persons, families and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.

Grievance procedure information is available in frequently used areas, particularly where people receive services. Such notices include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.

The organization provides access to persons and advocates, including a DMH internal advocate and the grievance process without reprisal.

Responses to grievances/complaints are provided within a timely manner as specified in the agency's procedures and in a manner that the person can understand.
The organization implements a system to periodically, but at least annually, review all grievances and complaints for quality assurance purposes.

Within ninety (90) days of employment, all employees who directly provide supports to people receive training in the following areas: Rights of people served, to include the recipient complaint/grievance procedure.

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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**
X ☐	**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.

Alabama Division of Developmental Disabilities, which is one division of the Alabama Department of Mental Health, is the Operating Agency for this waiver program. The notice of adverse action mentioned in Appendix F-1 includes an optional appeal to the Associate Commissioner of the Division of Developmental Disabilities. The consumer/family has the option to appeal in writing to the Associate Commissioner, who will arrange an appeal review, after which she or he will issue a decision within 21 calendar days. The notice also states that if the consumer/family disagrees with the Associate Commissioner's decision, they may appeal to the Medicaid Agency, and the notice indicates how and by when to do that.

The process will include a thorough review of all documents submitted with the initial application and may also include requests for additional information.

The types of disputes which can be addressed through this process include any adverse actions which have required the notice of due process to be sent to the consumer/family. Participation in this process is at the option of the consumer/family. If they choose not to participate, they may send their request for appeal directly to the Medicaid Agency.

In the rare instance that the adverse action includes terminating a service or dis-enrolling a person from the waiver who does not want to be dis-enrolled, the service will be continued until a review can be held, if the person appeals within the ten days prior of the effective date of the notice.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☐	**No. This Appendix does not apply**
X ☐	**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 Alabama Department of Mental Health, Office of Advocacy Services.

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).

The Department maintains an independent office of advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of AL business hours (the number is required to be posted in every certified site and given to each consumer), and investigates or causes to be investigated any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories:
a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h) Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; l) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.

Complaints of abuse, neglect or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than 7 working days of the report, with the expectation that the investigation will be completed within 30 working days.

Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy

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Program or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the consumer. If the consumer is receiving services under the waiver and his complaint involves waiver related issues, and he cannot achieve satisfaction through the required resolution, he and his representative are referred to the Medicaid Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services can resolve most problems.

Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, and if warranted, a notation of the resolution. These reports are provided to the staff of the Alabama Medicaid Agency

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*:

X	**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 Reporting Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Self-Neglect	Immediate
Mistreatment	Immediate
Exploitation	Immediate
Unnatural Death	Immediate
Moderate Injury	24-hours
Major Injury	24-hours
Choking	24-hours
Fall	24-hours
Seizure	24-hours
Other	24-hours
Medication Error Level I	24-hours
Medication Error Level II	Monthly
Medication Documentation Error	Monthly
Medication Error Level III	24-hours

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Missing/Eloped Consumer	Immediate
Natural Death	24 hours
Severe Behavior Problem	24-hours
Natural disaster	24-hours
Fire	24-hours
Physical Assault	24-hours
Sexual Contact	24-hours
Manual Restraint	24-hours
Mechanical Restraint	24-hours
Chemical Restraint	24-hours
Unscheduled Hospital Visit	24-hours

All DMH certified community providers shall report incidents involving individuals that occur in operated or contracted community residential and day programs, either on the provider's premises and/or while involved in an event supervised by the provider for all recipients of services. Reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with families).

Administrative Code Regulations:

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation
Each entity shall have a written plan that addresses the process of prevention and management of incidents.

The Division of Developmental Disabilities (DDD) preserves the safety, protection, and well-being of all individuals receiving services through its certified community agencies, and will take appropriate action on any mistreatment, neglect, abuse or exploitation of those individuals.

The DDD prohibits abuse, neglect, mistreatment and exploitation of individuals served, and has procedures for investigating and reporting such incidents, and for taking disciplinary and corrective actions.

The DDD has promulgated a Community Incident Prevention and Management Plan that provides guidance for community agencies/providers in the implementation of incident prevention and management systems to protect individuals from potential harm, and those agencies are required to implement this Plan as part of their DMH certification requirements.

All certified agencies are required to implement a Community Incident Prevention and Management Plan (IPMS) as required by the Division of Developmental Disabilities, to protect individuals served from harm and improve the agency's responsiveness to incidents for the purposes of prevention of harm and risk management.

Each certified agency must notify DDD of all reportable incidents and take actions in accordance with the Community IPMS requirements, which include state law and funding source requirements.

Each certified agency shall make changes/enhancements in the agency's Basic Assurances Plan as required by DDD to incorporate innovative strategies for the prevention and management of incidents, to address incident trends, and to update requirements of state law.

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.

Each person served by a provider agency is required by regulation to be informed of his rights and responsibilities annually. Rights include being free from abuse, neglect and exploitation. Each person is also informed of the Office of Advocacy toll-free hotline, its purpose and its number. Each person is also informed by the provider of their due process rights. Support Coordinators maintain relationships with individuals to encourage them to talk about what is important to them, including what may be happening that they don't like. The Office of Advocacy Services of the Department of Mental Health conducts routine random monitoring, and Regional Offices of the Division of Developmental Disabilities conduct routine monitoring, both of which include talking with individuals.

Administrative Code Regulations:

580-5-33-.04 Promotion and Protection of Individual Rights

The organization implements a policy and procedure that clearly defines its commitment to and addresses the promotion and protection of individual rights of people.

The policy lists rights afforded all citizens as indicated by the United Nation's Declaration of Human Rights, by the Constitution, laws of the Country and State of Alabama.

The policies and procedures describe the organization's required due process that includes a Human Rights Committee review and documentation of all proposed restriction of a person' rights.

The organization has no standing policies or procedures that restrict individual rights without due process.

The organization documents, upon admission and annually thereafter, verification that it provides to persons and their legally authorized representatives an oral and written summary of rights/responsibilities and how to exercise them, in language that the person understands.

Every person shall have the right to due process with regard to complaints/grievances and rights restrictions, within the agency or program providing services. Due process is, for these purposes, defined as providing the consumer, and/or their family or guardian, with a fair process that requires, at least, an opportunity to present objections to the proposed action being contemplated.

Dignity and Respect 580-5-33-.05 of Alabama Administrative Code At a minimum, the complaint/ grievance procedures shall include:

(a) The name and telephone number of a designated local contact within the entity.
(b) The designated person shall be able to inform persons of the means of filing grievances and of accessing advocates, ombudsmen, or rights protection services within or outside the agency.
(c) Grievance procedure information shall be available in frequently used areas, particularly where

people receive services. Such notices shall include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.

(d) Agency shall provide access to advocates, including a DMH internal advocate, and the grievance/complaint process without reprisal.

Procedures for the initiation, review and resolution of complaints and grievances shall be explained to the consumer/advocate and legal guardian.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures, including any procedures for placing a limitation or restriction on a person's rights. Each individual's ability to understand and exercise his or her rights is assessed and updated on an ongoing basis but at a minimum, annually.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period in which the restriction is imposed, and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures, including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-5-33-.04.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

Additionally, the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

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 Incident Manager housed in the Regional Office will review each incident report for each reportable incident described in G-1 a. and determine if the report requires no action follow-up, action follow-up, or an investigation. All allegations of abuse, neglect, mistreatment, or exploitation are incidents that, by regulation, require an investigation. Other incidents may or may not require an investigation, based on the nature of the incident and action already taken by the provider. Nonetheless, all defined incidents must be reported by the regulations governing certification of providers. Specifically, the provider is required to first assure the participant is safe and being treated as necessary, then report the incident, assess the cause, impact and needed actions regarding the incident, and address the needs so determined. The Regional Office reviews the provider' actions, as reported, to determine their adequacy.

Each Regional Office has a lead staff person n(Incident Manager) whose primary function is Incident Prevention and Management. This Incident Manager will have other staff of the Division available to assist as needed. For instance, Certification, Advocacy and Quality Enhancement staff are available, as is a registered nurse. A physician, psychiatrist and behavior analyst are also available on call (these are in 3 of the 5 regional offices). In addition, the Incident Manager can involve other professionals in the Regional Office who routinely monitor the provider in question, as well as anyone else who knows the participant, such as the support coordinator.

If the information submitted by the provider regarding an incident is sufficient to determine: a. the person is safe, b. the issues have been resolved, c. if the person needed anything more he is receiving it, d. an analysis has been conducted to determine if the incident could have been prevented, and e. that an analysis has been made to determine if there is a pattern that needs to be addressed, the Incident Manager will document this with a recommendation to the Regional Director that the incident requires no action follow-up. If the staff person recommends, and the Regional Director determines, that an incident requires action follow-up, then the Incident Manager will coordinate the efforts. Additional staff can be involved as mentioned above, and additional information is gathered either directly by the Incident Manager or through the provider. The Regional Office can and does assign actions to the provider, with timelines. Completion dates are not to exceed 15 days based on the nature of the incident.

If more information is required of an investigation, the Regional Office can extend the timeframe of an investigation. For example, the Regional Office can initiate its own investigation if they suspect the provider is not doing an adequate job, or has a track record of insufficient investigations, or has a clear conflict of interest. Also, the Regional Office will notify local law enforcement of possible criminal activity, if the provider has not done so and the information warrants it. Other entities that are routinely notified include DMH's Advocacy Office and the Adult Protective Services Unit of the Department of Human Resources. Investigation procedures have been trained and are retrained periodically, both for providers and for Regional Offices. Investigations must be closed within 15 days, unless there are extenuating circumstances, such as the absence of a necessary witness, or when repeated efforts to get information from the provider are required. Certification of the provider includes a review of the provider's compliance with factors 4, 5 and 6 and any failure to cooperate with other factors may results in a lowered certification score, which will cause the provider to be placed on provisional certification.

Community providers are required to immediately notify legal guardians/families of all incidents involving people served, regardless of the severity level. Providers are also required to notify legal guardians/families of investigation findings and the agency's plan to prevent similar incidents from

occurring in the future.

Participants are not routinely sent information by the DMH, regarding the status or outcome of an investigation. Rather, the provider will talk with the participant to explain any changes in his services that happen because of an investigation and will discuss the allegation and finding in more detail with a participant who will be able to understand what he or she is being told. Family members and other guardians will always be told the outcome by the provider and by the Support Coordinator. There are no instances in which the family members or guardians will not be notified about the outcome of an investigation. In addition, the participant, their family or their guardian may request a written summary of the investigation report, which DMH will provide.

Documentation of actions by the provider, by the Regional Office, and by others is maintained in a database at the DMH. This information is used to discern patterns and determine systemic interventions, as described in Appendix H.

Administrative Code Regulations: Each was summarized under G-1 a. above 580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation

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.

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Alabama Department of Human Resources (certain incidents of abuse, neglect and exploitation must be reported to ADHR by law).

Alabama Medicaid Agency: annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews. Quarterly review of Advocacy's reports.

Individual providers are required to report incidents to the perspective community service office (RCS). If the provider has provided sufficient information and corrective action, then the incident is closed. If the RCS office determines that additional information is required, a request for additional information is entered into the IPMS system to the provider agency, additional info is submitted to the RCS office, and the incident is closed. If the incident requires an investigation, the RCS may require the provider agency to conduct the investigation, rely on DHR and/or local authorities or Internal Advocacy, or conduct the investigation themselves. The RCS office Director reviews all investigations for completion and thoroughness. Any additional corrective action needs are requested of the provider and followed up until complete. Additionally, all investigation initiations and completions are forwarded to the Office of Quality and Planning for additional review and approval. Medicaid is informed of critical incidents that are systemic or otherwise rise to the level of decertification. Quarterly operating agency meetings are conducted by Medicaid in which providers on "provisional certification status" for violations of Best Possible Health, Protection from Abuse, Neglect, Mistreatment, and Exploitation and Safe Environments are discussed and actions being taken. Finally, Medicaid completes an annual audit of case management agencies and their sub-

contractors to review ADMHs certification process and needed follow-up.

Incident reports are submitted to the Regional Offices and entered into the IPMS system. These incidents are tracked by regional staff to completion and closure. In addition to the above, Regional QE Staff (1 in each of 5 regions) compile and analyze data on a quarterly basis for their region to identify any problematic trends or patterns. Individual provider and recipient issues identified are managed administratively by the Regional Office staff. Systemic educational development and training needs are managed by the QE staff. Also, on a quarterly basis, the Director of Quality and Planning compiles and analyzes data on a statewide basis and presents to the Developmental Disabilities Sub-Coordinating Committee, a statewide stakeholder group that makes remedial recommendations, as needed, to the Associate Commissioner for DD Services. Beginning 7/1/20, a Quality Council, to include a diverse group of stakeholders, will review this information and provide recommendations to the Associate. Commissioner for DDD Services.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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:
X ☐	**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).

The Behavioral Services Procedural Guidelines describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. Providers are required to train all staff who must implement restraints in the appropriate application of the procedures. If a person is found to be implementing the restraint incorrectly or outside the boundaries of an individual's Behavior Support Plan (BSP), whoever witnesses the event is obligated to report it, and the provider is required to submit an incident report and conduct an investigation regarding the inappropriate use, misuse, or unauthorized use of restraint. The Regional Community Services offices review any instances of this and follow up on the investigation, adding recommendations when necessary to those implemented by the provider to remedy the situation and prevent further occurrence. Any Emergency use of Restraint must be reported via the Incident Prevention and Management System (IPMS) procedures. If 3 of these occur within a 6 month period, the team is required to meet to determine the factors leading to the need for those restraints in order to determine what alternatives could have been tried more effectively and evaluate whether restraints should be added to the person's Behavior Support Plan (BSP). Additionally, at any time that Regional Office staff are conducting their usual monitoring of providers and they witness or become aware that any restraint has been used without authorization, it is reported and investigated. Finally, the Certification staff routinely reviews the use of any restrictive procedure during surveys to ensure appropriateness and adequate due process.

Every staff person who works with an individual for whom restraints are a part of their BSP must receive specific training regarding how to implement the restraint and under what circumstances the restraint can and cannot be used before they can work with the person. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe, challenging behavior as part of their orientation training as well as annual refreshers. Professional

staff must also have that kind of training. Direct Support Professionals are required to have a high school education. The QIDP must have a minimum of a bachelor's degree as well as training on the Behavioral Guidelines. Most of the providers who contract with the division do not use restraints. Most of the agencies that serve individuals who require restraints either employ or contract with a Board Certified Behavior Analyst (BCBA). Emergency use of restraints requires authorization from a QIDP, Program Director, or Physician. Direct Support Professionals cannot just decide to implement a restraint without that authorization.

Manual Restraints are listed in the Behavioral Guidelines as a Level 3 procedure in a BSP, which requires approval by the individual and his/her team, the Behavior Program Review Committee (BPRC), and the Human Rights Committee (HRC). Mechanical Restraints are listed in the guidelines as a Level 4 (most restrictive) procedure in a BSP, which requires all of the previously listed reviews/approvals and must also be submitted for approval by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities. The DPBS determines the frequency of additional reviews that will be required on a case by case basis for these Level 4 BSPs. Reviews by both the BPRC and HRC committees include that they ascertain whether less restrictive procedures have been tried and documented to be ineffective prior to approving restrictive procedures, including restraints.

Per the Behavioral Services Procedural Guidelines, Level 3 Procedures are restrictive and may only be used by direct care professionals when they are included in a Behavior Support Plan (BSP). Some of the procedures may be used in emergency situations and are so designated. Emergency use of these procedures requires an order from a QIDP. The use of an Emergency Procedure three times in a six-month period requires the individual's planning team to meet within five working days of the third use to determine if a BSP is needed. The team's determination must be documented. Staff must be trained in the use of these procedures prior to using. Each BSP containing Level 3 Procedures requires prior approval by the Behavior Program Review Committee (BPRC), review by the Human Rights Committee (HRC), and approval/consent by the individual or the parent/guardian and must be reviewed and updated at least annually.

Level 4 Procedures are considered the most restrictive and must be in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding the number of times it can be used). Each BSP containing Level 4 Procedures must be reviewed by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities, the BPRC, the HRC, and approval/consent by the individual or the parent/guardian. Requests for the use of these procedures should be sent to the DPBS, while consent requests are sent to the parent/guardian. The DPBS or designee will review and respond within two (2) working days of receipt of the BSP with the Level 4 Procedure. Staff must be trained in the used of approved procedures prior to using. The frequency for review and updating of the BSP with Level 4 Procedures will be indicated in the response sent by the DPBS or designee. However, a review is required at least annually.

Manual, Mechanical and Chemical Restraints are permitted in emergency situations and as procedures in properly designed and professionally monitored behavior support plans and implemented by trained staff, as follows.

There are three types of emergency restraints recognized in community programs:

1. Manual: the use of physical holding which is not a part of an approved behavior support

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plan to involuntarily restrain the movement of the whole or portion of an individual's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.

2. Chemical (psychotropic medication): the use of medication(s) that is not a standard treatment for the individual's medical or psychiatric conditions and is used to control behavior or restrict the individual's freedom of movement
3. Mechanical: The use of commercial devices which is not part of an approved behavior support plan to involuntarily restraint the movement of the whole or a portion of an individual's body as a means of controlling her/her physical activities in order to protect him/her or others from injury.

Positive Behavior and
Support Administrative
Code 580-5-33-.11
Objectives and strategies are developed to address behaviors that interfere with the achievement of personal goals or the exercise of individual rights using the least intrusive interventions necessary and the most positively supporting interventions available.

If appropriate, people have a behavior support plan that reduces, replaces or eliminates specific behaviors. Behavior Support Plans are implemented in accordance with the DDD Behavioral Services Procedural Guidelines.

Behavior Support Plans are developed based on information gathered through a functional behavioral assessment that is completed by a qualified professional and identifies physical or environmental issues that need to be addressed to reduce, replace or eliminate the behavior. The Behavior Support Plan outlines the specific behavioral supports that may and may not be used.

All direct support staff receive training in behavioral techniques and plans prior to implementation of support(s) to people.

Data related to the effectiveness of an individual's Behavior Support Plan is reviewed periodically, but at least quarterly, or more often as required by the individual's needs.

Prior to imposing a rights restriction, the person meets with his/her Support Team to discuss the reason for the proposed restriction, except in extreme emergency to prevent the person from harming self or others. Criteria for removing the restriction are developed and shared with the person and legally authorized representative prior to imposing the restriction.

All behavior support plans are approved by the person's Support Team. Each Behavior Support Plan with Level 2 or 3 procedures is reviewed and/or approved by the Behavior Program Review Committee, the Human Rights Committee and the person or the person's legally authorized representative in accordance with DDD PBS 02 Guidelines for Levels of Intervention.

(a) The use of emergency or unplanned behavior interventions that are highly intrusive are in compliance with DDD PBS 02 Level 3 Procedures and are not used more than three(3) times in a six (6) month period without a Support Team meeting to determine needed changes in the person's behavior support plan.
(b) If people require behavioral or medical supports to prevent harm to themselves or others,

such supports are provided in accordance with DDD Behavioral Services Procedural Guidelines (DDD-PBS 01 05).

(c) The use of any restraint complies with the provisions of DDD PBS 02 Level 3 Procedures and is applied only by staff with demonstrated competency for the device or procedure used.

(d) The organization ensures that people are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.

(e) The organization prohibits the use of corporal punishment, seclusion, noxious or aversive stimuli, forced exercise, or denial of food or liquids that are part of a person's nutritionally adequate diet.

(f) Behavior procedures considered the most restrictive comply with the Level 4 Provisions of DDD PBS

The use of psychotropic medications for behavior support comply with provisions of DDD PBS 02 Level 3 and are authorized by a licensed physician, preferably a psychiatrist. The use of medication(s) to reduce or change behavior associated with psychiatric symptoms shall be considered a Level 3 intervention (DDD PBS 02). These medications are authorized by the person's physician and incorporated into a Behavior Support Plan and/or a Psychotropic Medication Plan.

PRN orders for psychotropic medications are administered in accordance with the Nurse Delegation Program and the Behavioral Services Procedural Guidelines.

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:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Community providers are required to adhere to the Community Incident Prevention and Management System (IPMS) to eliminate, where possible the occurrence of preventable incidents and respond appropriately to reportable incidents.

Factor 4: Protection from Abuse, Neglect, Mistreatment and Exploitation (580-5-33.07) states that the organization implements policies and procedures that define, prohibit and prevent abuse, neglect, mistreatment, exploitation and unauthorized use of restraints.

ADMH-DD Behavioral Services Procedural Guidelines (updated 2014) indicates that use of emergency restraints 3 or more times in a 6-month period requires the Interdisciplinary Team (IDT) to meet and consider whether incorporating its use into a formal Behavioral Support Plan (BSP) is appropriate. As a result, ADMH-DD tracks data for the use of 3 or more unauthorized/inappropriate restraints in a 6-month period for individuals that did not have a BSP to address such interventions.

Incident Managers conduct daily reviews of General Event Reports (GERS) in the DD Incident Management System, Therap. The Regional Community Services Incident Review Committee conducts weekly meetings to review reportable incidents and make recommendations to community providers regarding quality of services provided.

Moreover, restraint data and other reportable incident data are collected and analyzed on a quarterly basis by Regional QES. Multi-Event Summary Reports are generated which outline all reportable incidents that occurred within each quarter. Therap enables QES to aggregate and export restraint data into an excel spreadsheet. QES filter restraint data by name to identify individuals that were subjected to an unauthorized/inappropriate use of a restraint.

Individuals meeting the threshold of 3 restraints are identified, and the GERs are reviewed to determine if the community provider and/or case management agency convened a special team meeting. The purpose of the meeting is to discuss changes in behavior that warrant excessive restraints and discuss a plan to develop a BSP to develop procedures for addressing such behaviors. Agencies that have not held special meetings to discuss are prompted to do so by the Regional Incident Manager.

The Director of Quality Enhancement collects aggregate incident data, including excessive use of restraints from the Regional Incident Manager and QES and compiles data for waiver reporting.

b. Use of Restrictive Interventions

☐	**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:
X	**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.

The behavioral guidelines describe all of the behavioral training and intervention strategies that are approved for use in Alabama. There are four (4) levels of procedures with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. Level 2 procedures, considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC, include: Escape Extinction, Negative Reinforcement, Positive Practice, Reparation of Property or Restitution, Response Cost Restriction of Environmental Access, Restriction of Movement inside or outside facility, Search, and Exclusionary Timeout procedures. Level 3 procedures require review by the entire BPRC and HRC prior to implementation and include: Modification of Clothing to Limit Access to Self, One to One Staffing due to behaviors, Overcorrection, Manual Restraint, Restriction of Personal Property/Visitors/Phone Calls, Use of Psychotropic Medications, and Closed-Door Timeout.

Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure. There are only four procedures listed at this level of intervention: Mechanical Restraint – Programmatic Use, Mechanical Restraint – Emergency Use, Sensory Screening, and Manual Restraints not otherwise specified in Level 3 (these would be modifications of the usual manual holds that may need to occur with a person). ALL the restrictive procedures must be directly related to a behavioral challenge and the function being served by that behavior. There must also be training and reinforcement to assist the person in developing more appropriate behaviors to replace the one(s) that led to the restriction. Furthermore, there must be a plan for lifting the restriction that is reasonable in terms of the individual being able to achieve the criteria set. Procedures that are prohibited include: Use of aversive stimuli, such as spray mists or bitter tasting liquids contingent upon behaviors occurring and Corporal Punishment of any kind. While there is not a section in the behavior guidelines that lists the procedures as specifically prohibited, they are not allowed by virtue of not being in the procedures listed. Some of the definitions of procedure do refer to the fact that these are not allowed when the acceptable procedures are defined.

Prior to being assigned to a person who has a BSP, each staff person who works with an individual for whom restrictive procedures are a part of their BSP must receive specific training regarding how to implement the procedure and under what circumstances they can and cannot be used. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe Challenging Behavior as part of their orientation training as well as via annual refreshers. Professional staff must also have that kind of training. All individuals must have Person Centered Plan in which the procedures of a BSP must be included and approved by the team and the person and then approved by the BPRC and HRC and, for the most restrictive procedures, by the DPBS. The Division of Developmental Disabilities offers training opportunities to assist service providers develop the skills related to determining the functions of behaviors being exhibited by individuals served and to connect the prevention and intervention strategies to the behavioral functions in order to increase the likelihood of successful outcomes. BSPs require renewal on an annual basis and all the review/approval groups mentioned above must assess the new plan and determine whether to approve the revised or new plan based

upon the data presented from the previous program. Finally, certification staff routinely review personnel files for all necessary and required training.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated.

Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-3- 26.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

In addition to the requirements in Chapter 580-3-26 (2)(a)-(3), the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

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:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Level 2 procedures, considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC. Level 3 procedures require review by the entire BPRC and HRC prior to implementation. Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure.

DDD Certification staff routinely review personnel files for all necessary and required training.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

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.)*

X	**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 Operating Agency, in its function of certifying providers, and in its monitoring of direct service provision and service plan implementation, will detect any unauthorized use of restrictive interventions either through records (for instance, notes in a participant's file communicating the restriction), staff comments and discussion, or participant or family feedback during direct interviews or through communication with the advocacy hotline.
	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 in the specification 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-3: Medication Management and Administration

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.

The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for purposes of addressing/treating behavioral challenges and/or Psychiatric Symptoms, a Psychotropic Medication Plan be developed for the purpose of ensuring that reductions are considered and implemented whenever possible, based upon presentation of data to the treating Psychiatrist/Doctor. The person's habilitation team provides documentation of behavioral data and reports of psychiatric symptoms (if applicable) at every session with the treating doctor for review. If the criteria set by the team have been met, this information is presented to the doctor, and consideration is given to a reduction in medication, unless contra-indicated for medical or other extenuating circumstances that should be documented. The medication plan can be a section within the person's BSP. If a person is having "spikes" in their behaviors or in psychiatric symptoms, the provider is required to attempt to determine what factors might account for those peaks and make their findings known to the doctor. They are also required to modify the person's plan, if necessary, to address the factors leading to the ineffectiveness of the medications. Finally, the Certification staff routinely reviews records of individuals receiving Psychotropic Medication for all necessary monitoring and documentation, including necessary lab work.

Sometimes individuals have behavioral episodes that result in visits to an ER or an admission to a hospital. This requires that notification be provided to the Regional Community Services office, and the IPMS procedures are followed in those cases. If it becomes evident that there are problems with medication administration, follow-up monitoring and, sometimes, investigations are conducted as outlined in the IPMS. Finally, the Certification staff routinely reviews information related to Best Possible Health, Protection for Abuse, Neglect, Mistreatment, and Exploitation, and Safe Environments.

Medications are reviewed through the IPMS system, quarterly regional and statewide QE reports, agency participation in the Nurse Delegation Program, and routine and "for-cause" certification reviews.

Provider-employed or contracted nurses directly administer certain medications and delegate

State:	
Effective Date	

others to trained direct care staff. The nurse is responsible to provide periodic and regular evaluation and monitoring of the staff performing the delegated task and to conduct quality monitoring of the tasks performed by the staff. This evaluation and monitoring must occur at least quarterly. Direct care staff must be medication assistant certified (MAC) workers in order to assist with medication administration. The delegating RN or LPN may withdraw delegation authority (of direct care staff) at any time.

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.

Alabama Department of Mental Health:
--Division of Developmental Disabilities

Three teams of professionals, including a medical doctor, a psychiatrist and a behavior analyst, are available through the Regional Offices to advise and assist with programs for reducing medications. These teams also provide education to local doctors who sometimes do not know the risk factors and alternatives to combinations of certain medications.

Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas for improvement. Data are collected, and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

Incident reports that include medication errors in three categories are required by IPMS and entered into an electronic database where they are tracked at the consumer and provider level and trended at the systems level. Intervention will occur from the Regional Offices and/or from Certification as needed.

Certification surveys include reviews of nursing notes and incident reports every year or every other year, depending on the overall score achieved by the provider on the previous survey.

Certification surveys also include for cause surveys and provisional status re-surveys as needed.

--Office of Advocacy Services

Advocates review individual's living situations, including issues regarding health and welfare, as well as rights, and check on medication administration on a sample basis.

Alabama Medicaid Agency:

Annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews.

State:	
Effective Date	

Annual survey of providers, including a complete record review on a sample basis.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

☐	Not applicable (*do not complete the remaining items*)
X ☐	**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).

State policy follows the nursing practice act of the State. Certain types of medication administration must be performed by a nurse, but other types, such as assisting with the delivery of prescribed oral, topical, inhalant, eye or ear medications may be delegated to a trained direct care staff under a protocol approved by the Board of Nursing.

iii. Medication Error Reporting. *Select one of the following:*

X	**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:
	Alabama Department of Mental Health: --Division of Developmental Disabilities The Division of Developmental Disabilities provides ongoing reports to the Alabama Board of Nursing. Agency reports to the DDD are included in the DDD reports to the Board of Nursing annually.
	(b) Specify the types of medication errors that providers are required to *record:*
	A medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error. Severities of medication errors are defined as follows: Level 1 includes incidents in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required. Level 2 includes incidents in which the individual experienced short term, reversible adverse consequences and treatment(s), and/or intervention(s) was/were needed in addition to monitoring and observation. Level 3 includes incidents in which the individual experienced life-threatening and/or permanent adverse consequences. The agency must record level 1, 2 and 3 medication errors.
	(c) Specify the types of medication errors that providers must *report* to the state:
	The agency must report level 1, 2 and 3 medication errors to RCS. Levels 2 and 3 must be reported verbally within 24 hours. Levels 1 and 2 must be reported on an incident form monthly. Level 3 must be reported on an incident report form within 72 hours. No action follow-up is required by RCS or the provider for Level 1 medication errors, but such errors are tracked and trended to determine patterns and need for possible intervention.
	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.

Alabama Department of Mental Health:
--Division of Developmental Disabilities

Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas for improvement. Data are collected, and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

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.)

i. **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 satisfaction survey respondents who reported that their health and safety needs are being met. Percentage = NUMERATOR [Number of survey respondents who reported that their health and safety needs are being met.] / DENOMINATOR Total number of survey respondents reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
NCI-AD and NCI Survey	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			X Other Specify:
			Sample size deemed appropriate by NCI.

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of suspected abuse, neglect and exploitation incidents referred to Adult Protective Services, Child Protective Services and/or law enforcement. Percentage = NUMERATOR [Number of total incidents that were referred to Adult Protective Services, Child Protective Services and/or law enforcement] / DENOMINATOR [Total number of instances of suspected abuse, neglect and exploitation]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Critical events and incident reports	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:
			Sample size deemed appropriate by NCI.

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing

State:	
Effective Date	

	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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.

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 that have been resolved by the Operating Agency within 30 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by the Operating Agency within 30 days of the date of the critical incident report date] / DENOMINATOR [Total number of reported critical incidents]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Critical events and incident reports	

	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)*
	X State Medicaid Agency	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ *Other Specify:*	*X Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other*	

State:	
Effective Date	

		Specify:		
				Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*Weekly*
Operating Agency	*Monthly*
Sub-State Entity	*Quarterly*
Other Specify:	*X Annually*
	Continuously and Ongoing
	Other Specify:

Performance Measure:	Number and percent of abuse, neglect, exploitation, or unexplained death incidents reviewed/investigated within the required timeframe. Percentage = NUMERATOR [Total number of abuse, neglect and exploitation or unexplained death incidents/investigated within the required timeframe] / DENOMINATOR [Total number of abuse, neglect and exploitation or unexplained death incidents/investigated]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Critical events and incident reports	

	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)*
	X State Medicaid Agency	*Weekly*	*X 100% Review*
	X Operating Agency	*Monthly*	*X Less than 100% Review*
	Sub-State Entity	*Quarterly*	*X Representative Sample; Confidence Interval =90*
	Other Specify:	*X Annually*	
		X Continuously and Ongoing	*Stratified: Describe Group:*

State:	
Effective Date	

		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of unreported incidents of abuse, neglect, mistreatment, exploitation and unexplained deaths that were identified during the site visit. Percentage = NUMERATOR [Total number of unreported incidents of abuse, neglect, mistreatment, exploitation, and unexplained deaths that were identified during site visit] / DENOMINATOR [Total number of unreported incidents of abuse, neglect, mistreatment, exploitation, and unexplained deaths]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Provider Performance Monitoring	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	☐ *X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	☐

State:	
Effective Date	

		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of critical incident trends where systemic intervention was implemented. Percentage = NUMERATOR [Total number of critical incident trends where systemic intervention was implemented] / DENOMINATOR [Total number of critical incident trends]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Critical events and incident reports	

	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)*	
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*	
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*	
	☐ Sub-State Entity	*☐ Quarterly*		*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*		

State:	
Effective Date	

		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

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 with restrictive interventions where proper procedures were followed. Percentage = NUMERATOR [Number of participants with restrictive interventions where proper procedures were followed.] / DENOMINATOR [Number of individuals reviewed who had a restrictive intervention applied (reported and not reported)]

State:	
Effective Date	

Data Source *(Select one) (Several options are listed in the on-line application):*
If 'Other' is selected, specify:
Critical events and incident reports

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of restraints applied three (3) times in a six month (6) period that resulted in a team meeting. Percentage = NUMERATOR [Number of times a restraint has been applied 3 times within a six month period resulting in a team meeting] / DENOMINATOR

State:	
Effective Date	

	[Number of times a restraint has been applied 3 times within a six month period]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Critical events and incident reports	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.

State:	
Effective Date	

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 people who responded that their overall health was Good, Very Good, or Excellent. Percentage = NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent.] / DENOMINATOR [Total number of survey respondents]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
NCI-AD and NCI Survey	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			X ☐ Other Specify:
			Sample size deemed appropriate by NCI.

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. Percentage = NUMERATOR [Number of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of providers reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Provider files	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

State:	
Effective Date	

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. Percentage = NUMERATOR [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of case managers reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Case manager files	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other	

State:	
Effective Date	

		Specify:		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.

Data from the OA will be collected on a monthly basis and reported to AMA. Trends in data will be addressed as appropriate depending on the results. Remediation by the QE staff in the regional office will identify needs based on trends and act accordingly to minimize variances from the expected goal.

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.*

Reports will be sent monthly to the AMA and data will be reviewed. Data reports will be discussed at quarterly meetings to discuss data and trends noticed by AMA. AMA will work with the OA to ensure correction in an efficient manner. Regional nurses are required to monitor 5% the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and

identify areas of improvement. Data is collected and reviewed recommendations are made on the Regional Nursing Monitoring on ways to prevent medication errors on the appropriate form. Regional nurses follow-up to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

ii. Remediation Data Aggregation

	Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies)*
	X State Medicaid Agency	**Weekly**
	X Operating Agency	**Monthly**
	X Sub-State Entity	**X Quarterly**
	Other Specify:	**Annually**
		Continuously and Ongoing
		X Other Specify:
		5% of Medication Administration records are reviewed annually.

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.

X	**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

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.

State:	
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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; and
- 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 QIS* 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 QMS 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.

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.

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.

Appendix A Medicaid Oversight: Medicaid Agency will trend and analyze and share findings with the Administration of the Operating Agency. The quality assurance and improvement methodology employed by Medicaid staff gathers information from on-site and off-site record reviews and direct observation, as well as, from data forwarded from the operating agency. Weighting and trending of the multiple data elements is achieved with an algorithm designed by the University of Alabama at Birmingham to be used for all the State's HCBS Waiver Programs.

Appendix B Level of Care Evaluations: The Administration of the Operating Agency will jointly consider the findings from the performance measures and determine the necessary actions. Specifically, the Director of System Transition and Waiver Development will trend and analyze quarterly and annually; the Associate Commissioner will prioritize; and the Director of Case Management Services and/or the Director of Quality and Planning will implement the prioritized recommendations with the support of the Directors of the Regional Community Service Offices. All system changes are shared with the Alabama Medicaid Agency prior to implementation.

Appendix C Qualified Providers and Certification: The Administration of the Operating Agency will jointly consider the findings from certification surveys and the related performance measures and determine the necessary actions. Specifically, the Director of Quality and Planning will analyze and trend the information quarterly and annually and share this information with the Quality Council/Developmental Disabilities Sub-Coordinating Committee. This council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. Prioritized recommendations from the Council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix D Service Planning: The Director of Case Management review the information from the provision of Support Coordination by DDD staff persons and provide quarterly summaries of findings and recommendations. This information from the performance measures can be reviewed agency by agency, aggregated by region, and aggregated statewide. It can also be trended from quarter to quarter and year to year, within the same aggregation parameters. The Director of Case Management will analyze and trend statewide data and also consider and prioritize the recommendations of the Regional Offices. The Associate Commissioner will approve recommendations for implementation. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix G Health and Welfare: The Regional Offices review all incident and investigation reports quarterly and provide summaries and analysis to the Director of Quality and Planning, who shares this information, as well as statewide trends, with the Quality Council. Prioritized recommendations from this council will be

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reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes in the rule must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix I Fiscal Accountability: The Alabama Medicaid Agency will, through its monitoring process, discover problems and resolve them. The Medicaid Agency will also see, through trending of these monitoring reports, any areas of concern which may need to be addressed through efforts ranging from training to policy and regulation to changes in the MMIS edits and audits.

In conjunction with the Director of Quality and Planning, the Director of Systems Management will provide quarterly summaries and analysis of waiver discovery and remediation indicators. Quality Improvement Strategy data for Health and Welfare, as well as Level of Care, Qualified Providers, Service Planning, and Self-Directed Services will be presented during the same Quality Council/Developmental Disabilities Sub-Coordinating Committee meeting. This Quality Council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. If recommendations are made, they will be prioritized and reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which requires changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. Evaluation of the QIS plan is ongoing, as data is presented quarterly. The QIS will be updated to track discovery and remediation data as program requirements change. At a minimum, the QIS plan will be reviewed upon CMS three-year assurances review and updated upon renewal. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
X State Medicaid Agency	**☐ Weekly**
X Operating Agency	**☐ Monthly**
☐ Sub-State Entity	**X Quarterly**
☐ Quality Improvement Committee	**X Annually**
☐ Other Specify:	**☐ Other** Specify:

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.

All system design changes have a component of evaluation built into the plan before the design change is implemented. For example, the Division implemented a new set of regulatory standards October 1, 2012. The Division contracted with the Council on Quality and Leadership (CQL) to align our requirements with their Basic Assurances(c). The change required extensive and ongoing training of community services providers. It

included ongoing reports and evaluations by the Department of Mental Health, Division of Developmental Disabilities Certification Staff with community providers. Finally, training was provided by CQL to certification staff and has been validated annually.

The current direction of system design change is multifaceted. First, beginning October 1, 2014, the provider organizations will be required to develop and implement an ongoing quality enhancement plan or Basic Assurances System. Providers will complete an organizational assessment of their compliance with the Basic Assurances. Based on the assessment, they will have to identify priority areas to target for improvement for each factor and/or develop monitoring systems to ensure maintenance of compliance. Second, Divisional Quality Enhancement Staff entered into a training with CQL to become certified quality analysts. In this role, they have analyzed the first year of certification data and are developing focused trainings on specific areas both regionally and statewide to provide assistance to community organizations. Third, Divisional QE staff and other certified trainers are required to provide three (3) 4-day workshops in Personal Outcome Measures Training(c) as developed by CQL. The vision is for all waiver participants to participate in an outcome interview to determine preference, the presence or absence of outcomes and supports, and the priorities for attainment, which will become the foundation of the individuals' person-centered plans. This is how the Division envisions more effective person-centered planning in order to meet the CMS Regulations regarding Home and Community Based Services.

ii. **Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.**

ADMH-DD's Quality Council Committee meets during the DD Coordinating Subcommittee (also referred to as DD Sub) on a quarterly basis to receive reports from DD staff regarding waiver services, provider certification, individual health and welfare (incident management), case management and budgeting. Recurrent trends and other issues are often identified by the committee and the responsible office is tasked with researching the area of concern, consulting with appropriate staff, and providing a resolution to the larger group in a timely manner. The committee is then afforded the opportunity to make inquiries, request follow-up information and make recommendations to further implement system improvements.

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- ○ No
- X Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ HCBS CAHPS Survey;
- ○ NCI Survey;
- X NCI Survey;
- ○ Other *(Please provide a description of the survey tool used)*:

Appendix I: Financial Accountability

APPENDIX 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).

The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:

The Alabama Medicaid Agency will serve as the administering agency for this Waiver Program. The operating agency will be the Alabama Department of Mental Health. The Medicaid Agency and the Department of Mental Health are both audited externally by the Alabama Department of Examiners of Public Accounts on an annual basis.

The Operating Agency is responsible for initial certification and annual audits of providers. The audits completed by the OA have a confidence level of 95% with a +/- 5% margin of error. All providers are required to secure an independent audit of their financial statements. Medicaid's Networks and Quality Assurance Division takes a sample of each type of provider over a rolling three-year period to audit from all Waivers. Data is collected from providers by any of the following sources: reviewing a sample of the waiver case management records, direct service providers records, consumer satisfaction surveys, and tracking complaints and grievances. Additionally, the plan of care and data sheets are reviewed and compared against the plan of care to ensure that services were provided according to the plan of care.

Medicaid will choose one provider from each type (roughly about 15 types of providers across all Waivers) each quarter to audit (desk review). Audits do not differ by service or provider. The results of the audit are provided to the Operating Agency. Medicaid does not have a direct contract with the provider; therefore, it is the responsibility of the OA to credential and provide audit feedback to the provider. If AMA finds 15 or more discrepancies (total from the administrative, personnel, training, and client tool components) between its audit findings and the OA's audit findings for a given provider, AMA will issue a Corrective Action Plan (CAP) indicating the steps the OA must implement within a designated timeframe to remedy the issues.

Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped. Medicaid implemented the following system to ensure services are billed according to the plan of care to produce more accuracy in billing:

On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. The EVVM system will enable more accuracy in service tracking, reporting, and billing for in-home care providers. The Electronic Visit and Verification system performs automated scheduling, time/attendance tracking and claim submission that:

* *Maintains a repository of authorized services*
* *Allows web-based scheduling of service visits*
* *Verifies a workers' location and length of service visit*
* *Automatically creates a claim record for review*

State:	
Effective Date	

* *Identifies late or undelivered services*
* *Issues alerts for late and missed visits*
* *Automatically submits claim records for payment*
* *Provides flexible reporting in real-time*
* *Check in/out immediately reflected on the web*

The Electronic Visit Verification and Monitoring system requires the worker to check-in and check-out using the worker's mobile devices to log the visit on the EVVM app or by using the recipient's phone to dial into an Interactive Voice Response system. The system provides GPS location authentication and real-time communication to view and monitor by the provider, Operating Agency, and the Alabama Medicaid Agency. This system ensures the integrity of providers billing for Medicaid payment of waiver services. The EVVM system reduces fraud and errors and is a proactive monitoring tool. Providers can monitor and review claims in real time and confirm claims for payment upon review. Additionally, the system will alert the case managers/providers when critical services are missed or late, thus preventing an overpayment for services not performed.
Service authorizations are loaded into the system from the Operating Agencies, thus preventing the provider from adding or editing the authorization for services. A claim cannot be confirmed and submitted for payment without a valid authorization. A visit can be scheduled only if there is an authorization for that service and client. A warning message pops up if the visit conflicts with another or not enough remaining units in the authorization, thus preventing fraudulent billing or an overpayment.

Every service captured by the Mobile app or IVR, or entered via the Web creates a claim. The provider has to confirm the claim before they are submitted for payment. Behind the scenes editing occurs continuously based on AL business rules and billing requirements. The provider can edit claims; however, a report can be produced to monitor if a provide has a systemic issue with editing claims which can raise a flag of fraud.

Another method that ensures the integrity of providers billing for Medicaid payment of waiver services is through the ADIDIS system for the Alabama Department of Mental Health. The provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. The ADIDIS system checks claims prior authorizations to ensure the services billed are approved by the Operating Agency's review of the plan of care. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.
Medicaid's Networks and Quality Assurance Unit reviews a sample of waiver case management records and additionally the plan of care and data sheets are reviewed and compared against the plan of care to ensure that services were provided according to the plan of care. Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped.
The Fiscal Agent Liaison Division/Contract Monitoring Unit (DXC) of the Alabama Medicaid Agency monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Errors are identified real-time and corrections initiated. For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider. The claim is processed using both clerical and automated procedures. Once the claim pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. The system 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 compares them to Alabama Medicaid policy. The claim is then assigned a status (approved to pay, denied, or suspended). Suspended claims must be worked by DXC personnel or reviewed by Alabama Medicaid Agency personnel, as required. Claims paid in error will be submitted for recoupment.
Once the reviewer initiates the recoupment, the claims goes back through the system and the FFP is removed. Monthly reports of expenditures are received by the designated Long Term Care staff in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.
The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

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.)*

a.i. 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 claims that are supported by documentation that services were delivered.

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	Percentage = NUMERATOR [Number of claims reviewed that are supported by documentation that services were delivered] / DENOMINATOR [Number of claims reviewed]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Claims data and participant records

	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)*	
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*	
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*	
	☐ Sub-State Entity	*X Quarterly*		*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*		*+/- 5%*
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of claims paid for participants who were eligible on the date the service was provided. Percentage = NUMERATOR [Number of claims paid for participants who were eligible on the date the service was provided] / DENOMINATOR [Number of claims paid]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Claims data	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		X☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Performance Measure:	Number and percent of claims paid for a service that was specified in the participant's service plan. Percentage = NUMERATOR [Number of participant records sampled that show that the service paid for was included in the participant's service plan] / DENOMINATOR [Number of participant records in the sample]

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Claims data and participant records

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/- 5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

State:	
Effective Date	

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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 claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Percentage = NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver] / DENOMINATOR [Number of claims paid]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Claims data	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =90*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

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Effective Date	

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology] / DENOMINATOR [Number of rates reviewed]
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Claims	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ Other Specify:	*X Annually*	*+/-5%*
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

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Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.*

Reports are shared with the Operating Agency and the Performing Provider. Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped. The phrase "not provided in accordance..." is defined as exceeding an average expected rate of utilization by more than 10% and having no documentation for the exception. All waiver services are prior authorized, so that the annual limits on units of service cannot be exceeded, but average utilization, month to month, can vary.

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)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **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 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-2: Rates, Billing and Claims

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).

Proposed service rates are determined by the Alabama Department of Mental Health / Division of Developmental Disabilities (Operating Agency) and are reviewed and approved by the Alabama Medicaid Agency, which has oversight of the rate determination process. Payment made by Medicaid to providers for this waiver will be on a fee-for-service basis, with some outcome payments using methodologies (described in more detail below) known to be used in other states' 1915(c) waivers for certain pre-employment services. Rates are based upon a number of factors and all rates were formulated using the following: current pricing for similar services and stakeholder feedback on this pricing; state-to-state comparisons for similar services; comparison of different payers for similar services; and attention to the expansion of capacity providers must undertake necessary to serve more individuals given this waiver is adding a minimum of an additional 500 individuals with ID in targeted pilot areas in each region of the state. Rates do not vary geographically.

The rates, once approved by CMS, will be posted on ADMH website. Rates must be sufficient to recruit an adequate supply of qualified providers for each service to ensure participants have adequate access to waiver services. Rates established are reasonable and customary to ensure quality of service, continuity of service and availability of providers necessary to ensure timely access to services that are needed. Stakeholders have the opportunity to provide input into the development and sufficiency of rates through the posting of waiver applications, renewals and amendments for public comment, the ADMH DD Sub-Committee, and other stakeholder meetings and forums. Where stakeholder input and state-to-state comparison of payment rates for similar services consistently supported the need for payment rates for particular services to be set above the rates in the existing LAH and ID waivers, higher rates have been adopted to ensure rate sufficiency while still adhering to requirements under §1902(a)(30)(A). All rates are supported by rate models containing appropriate and reasonable assumptions about provider costs to deliver each service. Rates for 1:1 service delivery are appropriately adjusted when/if more than one individual can be supported by one staff person in the delivery of a specific waiver service.

For the three models of residential support (Supported Living; Adult Family Home; and Community-Based Residential Services) rate ranges are proposed with individual waiver participant rates set based on use of an assessment tool that takes account of the specific type, frequency, and intensity of the different kinds of supports the individual needs, also taking into account whether Remote Supports is being utilized, whether more than one individual is sharing support at certain times, whether nurse oversight/delegation is needed, and the extent of transportation the provider is expected to provide. Supported Living-Non-Intensive utilizes a weekly rate that best aligns with ensuring flexibility for the individual while paying based on a unit that still assures fiscal integrity in the development of the individual rate. Supported Living-Intensive and the other two residential service types use a daily rate. ADMH has contracted with an agency from another state with twenty years of experience administering services for people with ID, including all three residential models being offered through this waiver. This agency has developed and implemented the Supported Living assessment tool and is assisting ADMH with adopting this tool for this waiver as well as assisting with the development of similar tools for Adult Family Home and Community-Based Residential Services, and training of Support Coordinators and providers on use of the tools.

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For Supported Employment–Individual Job Coaching services, fee for service job coaching rates are based on a prospective rate model that reflects a sufficient wage for the level of qualified staff required to deliver the service and all other reasonable and anticipated costs involved in providing the service. For job coaching, this prospective rate is then tiered into three distinct rates based on the level of fading achieved, taking into account the waiver participant's level of disability and length of time the job has been held. Providers can earn the highest rate for achieving the highest fading targets, the mid-level rate for achieving the mid-level fading targets, and the base level rate for achieving the base level fading targets. Using this model, providers are appropriately incentivized to fade job coaching supports over time (a key quality metric for supported employment services) while the state can also ensure no waiver participant is excluded from participation in supported employment-individual services based on level of disability or newness to their job. To determine a waiver participant's acuity tier for job coaching, the ICAP assessment score that has been in use to determine residential and day service reimbursement in the LAH and ID waivers will be used. Additionally, where an individual has a need for job coaching that is equal to or less than one hour per week, a monthly "Stabilization and Monitoring" payment will be used to encourage ongoing, effective monitoring of the waiver participant's employment situations, with minimum monthly contact requirements that will allow for prevention of otherwise avoidable job losses or reductions in work hours.

For Supported Employment-Individual pre-employment services, the state proposes to pay on an outcome basis. The following rate determination methods were used:
Exploration: Underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by Alabama Division of Rehabilitation Services and in the LAH and ID waivers. All components of Exploration service process were defined and the average time necessary for each step was determined, resulting in an average of 30 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 30 hours to arrive at the outcome payment. The required Exploration report, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time. The providers will also be given the Exploration Steps and Timeframes, that the outcome payment is based on, prior to receiving an authorization for this service.

Discovery: Underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by Alabama Division of Rehabilitation Services and in the LAH and ID waivers. All components of Discovery service process were defined and the average time necessary for each step was determined, resulting in an average of 34 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 34 hours to arrive at the outcome payment. The required Discovery report, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time. The providers will also be given the Discovery Steps and Timeframes, that the outcome payment is based on, prior to receiving an authorization for this service.

Job Development Plan: Underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by Alabama Division of Rehabilitation Services and in the LAH and ID waivers. All steps necessary to create a Job Development plan with the waiver participant were defined and the average time necessary for each step was determined, resulting in an average of 6 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 6 hours to arrive at the outcome payment. The required Job Development Plan, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time. The providers will also be given the Job Development Plan Steps and Timeframes, that the outcome payment is based on, prior to receiving an authorization for this service.

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Job Development: Underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by Alabama Division of Rehabilitation Services (ADRS) and in the LAH and ID waivers. Using information from other states Medicaid HCBS programs, ADRS, and vocational rehabilitation agencies in other states, the average amount of hours necessary for completion of job development (securing outcome of paid competitive, integrated employment, consistent with a waiver participants goals, preferences, skills and conditions for success) was determined. The average hours expected to be necessary to complete the service were multiplied by the underlying fee-for-service prospective rate for the qualified job developer to arrive at the outcome payment. The required Job Development report, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time.

Career Advancement: Underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by Alabama Division of Rehabilitation Services and in the LAH and ID waivers. The service is divided into two parts: Career Advancement Plan and Career Advancement Outcome. The same assumptions used for Job Development Plan creation were used for the Career Advancement Plan. Thus, the average time necessary was determined to be 6 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 6 hours to arrive at the outcome payment for the Plan. The required Career Advancement Plan, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time. For securing the advancement opportunity, a lower outcome payment than for initial Job Development was established, based on fact person is employed and successful in their current employment. The average hours expected to be necessary to complete the service (18.75) were multiplied by the underlying fee-for-service prospective rate for the qualified job developer to arrive at the outcome payment. The required Career Advancement report, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the state to monitor the appropriateness of the outcome payment over time.

Reviewing the rates and assumptions in the rate methodologies will occur on an ongoing basis to ensure adjustments are made as needed. Re-evaluation of pricing and rate increases will be considered as warranted based upon problems with service access, service quality, and budgetary opportunities. In cases where allocations from the state Legislature are received, rates increases are determined by the OA based on problems with service access, service quality, stakeholder input, and where service rates have not been adequately adjusted over time due to budget constraints.

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 Recipient Level of Care Panel. This file holds approved dates of eligibility for waiver services.

Provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. This system, known as ADIDIS, checks claims against prior authorizations to ensure the services billed are approved by the operating agency's review of the plan of care. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary as follows:

Payments made by Medicaid to providers are on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

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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.

If the submitted claim 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.

Payment is based on the number of units of service reported on the claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from the point of service through billing and reimbursement. Discrepancies are initially handled at the local level.

The ID Waiver administrator monitors expenditures on a bi-annual basis or as often as needed and monitors problems with particular service providers. If costs appear to be out of line or unusual, the provider is contacted and follow-up action is implemented as needed.

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 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.

c. Certifying Public Expenditures *(select one)*:

X	**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.*)

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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 procedure 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 systems 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 DXC Technology 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 write 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-3: Payment

a. Method of payments — MMIS *(select one)*:

X	**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) 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:

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.
X	**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.

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:*

X ☐	**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.

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.*
X ☐	**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. *Complete item I-3-e.*
	State DMH (Alabama Department of Mental Health) is the operating agency for this waiver. The State DMH provides Support Coordination to all waiver participants.

e. Amount of Payment to State or Local Government Providers.

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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*:

X	**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:

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:*

X	**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.

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.
X	**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.
	Providers may reassign payments only to ADMH, the operating agency for this waiver.

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.**
X ☐	**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: *The ADMH and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish; but in this case, they must also contract with the ADMH in order for the ADMH to pay the state match portion of the reimbursement. Free choice of provider as detailed elsewhere in this waiver application is assured by the policies and procedures in effect and practices carried out by Support Coordinators. All providers are certified and monitored between certification surveys.* *Payments are made through an approved MMIS system which ensures financial accountability.*

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

X ☐	**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-4: Non-Federal Matching Funds

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**
X ☐	**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 non-federal share of waiver payments is transferred to the Alabama Medicaid Agency by the Alabama Department of Mental Health (ADMH). This is managed through an IGT process in which the Medicaid Agency determines, during each billing cycle, how much non-federal match is needed to reimburse adjudicated claims, and invoices ADMH, whereupon ADMH transfers these funds to the Medicaid Agency. *For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the AL Department of Mental Health is 100% appropriated by the legislature to the ADMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust 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:

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:*

X ☐	**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

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		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:

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:*

X ☐	**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-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.**
X ☐	**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:

All costs related to room and board are clearly excluded from the formulas used to build the rate determination assessments for Supported Living, Adult Family Home and Community-Based Residential Services, as follows:

The rate setting methodology for these residential service options is driven by the staff hours needed by each individual, divided by the number of other individuals sharing those staff hours (staff hours). Transportation, the need for nurse oversight/delegation, if applicable, and the use of Remote Supports, assistive technology/adaptive aids, PERS, and natural supports is also factored into the rate setting methodology.

Indirect administrative and non-personnel operating costs are also factored in and clearly defined not to include room and board costs.

Participant's earned and unearned income pay for room and board.

APPENDIX 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:*

X ☐	**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:

State:	
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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

X	**No. The state does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
☐	**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

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*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	**Basis**

State:	
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iv. **Cumulative Maximum Charges.**

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

☐	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
☐	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

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:*

X ☐	**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

Appendix 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

J-1 Composite Overview and Demonstration of Cost-Neutrality Formula							
Column 1	**Column 2**	**Column 3**	**Column 4**	**Column 5**	**Column 6**	**Column 7**	**Column 8**
Year	**Factor D**	**Factor D'**	**Total: D + D'**	**Factor G**	**Factor G'**	**Total: G + G'**	**(Col 7 less Col 4)**
Year 1 (2020-2021)	$37,816	$5,922	$43,738	$87,954	$4,080	$92,034	$48,296
Year 2 (2021-2022)	$36,885	$6,044	$42,929	$89,774	$4,165	$93,938	$51,009
Year 3 (2022-2023)	$37,700	$6,169	$43,870	$91,631	$4,251	$95,882	$52,012
Year 4 (2023-2024)	$38,493	$6,297	$44,790	$93,527	$4,339	$97,865	$53,076
Year 5 (2024-2025)	$39,278	$6,427	$45,705	$95,462	$4,428	$99,890	$54,185

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Appendix J-2: Derivation of Estimates

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: ICF/IID	Level of Care:
Year 1: 2021	474	474	
Year 2: 2022	705	705	
Year 3: 2023	936	936	
Year 4: 2024	1,368	1,368	
Year 5: 2025	1,584	1,584	

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 (ALOS) is projected to be 352 days. The ALOS is derived based on the average of federal fiscal year (FFY) 2017 (October 1, 2016 to September 30, 2017) and FFY 2018 (October 1, 2017 to September 30, 2018) data from the Intellectual Disabilities (ID) and Living at Home (LAH) 1915(c) waivers. The ID and LAH waivers populations are representative of the population who will enroll in the Community 1915(c) waiver. Current ID and LAH 1915(c) waiver participants may enroll in the Community 1915(c) and include new enrollees who whose eligibility criteria meets the existing ID and LAH waivers.

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 and methodology for these estimates is as follows:

The average annual Factor D projection was developed using historical enrollment, utilization and expenditures for HCBS services provided under the ID and LAH 1915(c) waiver for FFY 2017 and FFY 2018. The data was aggregated for each population covered in the Community 1915(c) waiver. ID and LAH experience were selected because participants in the Community 1915(c) waiver will enroll from the current ID and LAH waivers or may be new enrollees who whose eligibility criteria meets the existing ID and LAH waivers. The historical service utilization and expenditures from ID and LAH were aggregated based on four populations outlined below:

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1. 3-13 years old who are living with family or with other natural supports
2. 14-21 years old who are living with family or with other natural supports, or who are 18-22 and live independently.
3. 22+ years old who are living independently or living with family or with other natural supports.
4. 3+ years old who are unable to live independently, live with family or other natural supports.

FFY 2017 and FFY 2018 data was blended together and trended from the midpoint of FFY 2017 and FFY 2018 (September 30, 2017) to the midpoint of Year 1 (December 31, 2020) using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5 (July 1, 2021 to June 30, 2025)

The Factor D figures reflect the annual expenditure limits for HCBS services by population outlined in Appendix C-4 . These annual limits plus the amount for 1915(c) waiver services not subject to the annual limit are the basis for the Factor D projections. The Factor D for each population was aggregated based on the slots available for Year 1 (July 1, 2020 to June 30, 2021). To derive Factor D for years 2 through 5 (July 1, 2021 through June 30, 2025)., the Year 1 amounts by population were trended at 2.07% and aggregated for the total available waiver slots during each year. The trend factor of 2.07% is based on the Bureau of Labor Statistics Consumer Price Index for medical services (CPI-U) from 2017-2019.

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′ for Year 1 was developed using historical enrollment and expenditures for state plan services from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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 was developed using historical enrollment and expenditures for ICFMR services from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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′ was developed using historical enrollment and expenditures for state plan services used by enrollees in ICFMR from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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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	
	manage components
	manage components
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	manage components

State:	
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d. Estimate of Factor D.

i. Estimate of Factor D – Non-Concurrent Waiver. 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. 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	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

ii. **Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col.6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

	Waiver Year: Year 2						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

	Waiver Year: Year 3						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

	Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Waiver Service / Component	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	