

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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

This renewal application does not contain any significant changes to the approved Home and Community Based Waiver for Individuals diagnosed with HIV/AIDS and Related Illnesses. However, the state made the following changes:

Appendix C-1  
Revised provider qualifications for Case Management services.

Appendix G-3  
Removed language regarding medication management and administration.

Appendix G-3 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.

Additionally, removed all language that refers to the Operating Agency as the Alabama Department of Public Health. An amendment was done previously to change the Operating Agency from the Alabama Department of Public Health to the Alabama Department of Senior Services and there were a few oversights.

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

### 1. Request Information (1 of 3)

**A. The State of Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Services Waiver for Individuals with HIV/AIDS and Related Illnesses

**C. Type of Request:** renewal

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

**3 years      5 years**

**Original Base Waiver Number: AL.40382**

**Waiver Number: AL.40382.R02.00**

**Draft ID: AL.002.02.00**

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

Model Waiver

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

10/01/12

**Approved Effective Date: 10/01/12**

**PRA Disclosure Statement**

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

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**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:

[Redacted]

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

The state does not limit the waiver to subcategories of nursing facility level of care.

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

**1. Request Information (3 of 3)**

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

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

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

**2. Brief Waiver Description**

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

The HIV/AIDS Waiver allows individuals with a diagnosis of HIV/AIDS and related illnesses who are at risk of nursing home placement to remain in the community as long as their health and safety is not at risk. The waiver seeks to provide quality, supportive, and cost effective services to individuals at risk of institutional care. Many services provided in this and other HCBS waivers offered by the state are traditionally not covered or available under the Medicaid State Plan.

The Alabama Medicaid Agency is the administering agency for this program and the Alabama Department of Senior Services (ADSS) is the operating agency. As the operating agency ADSS is responsible for the daily management and operation of the program. In the daily management of the program ADSS focuses on client outcomes such as improving client care, protecting client health and welfare, offering the client free choice of providers for waiver services and waiver service staff. Other ADSS management responsibilities also include assuring all direct service providers meet the required provider qualifications. The following services are provided in the HIV/AIDS Waiver program: case management, personal care, homemaker, respite, (skilled and unskilled), skilled nursing and companion services.

### **3. Components of the Waiver Request**

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
  - Yes. This waiver provides participant direction opportunities. Appendix E is required.**
  - No. This waiver does not provide participant direction opportunities. Appendix E is not required.**
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

### **4. Waiver(s) Requested**

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- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

**Yes**

**C. Statewideness.** Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

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

**Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

*Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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

**A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

**A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

**C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified

provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

Prior to submission of the initial waiver application for Individuals with HIV/AIDS and Related Illnesses the Medicaid Agency held a number of meetings with representatives from the Alabama Department of Public Health, AIDS Alabama and other Community Based Organizations with an interest in the population served by this waiver.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

Last Name:

McLeod

First Name:

Samantha

Title:

Associate Director, LTC Specialized Waiver Programs

**Agency:**

Alabama Medicaid Agency

**Address:**

501 Dexter Avenue

**Address 2:**

P.O. Box 5624

**City:**

Montgomery

**State:**

Alabama

**Zip:**

36103-5624

**Phone:**

(334) 242-5584

Ext:

TTY

**Fax:**

(334) 353-5536

**E-mail:**

Samantha.McLeod@medicaid.alabama.gov

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

Stone

**First Name:**

Jean

**Title:**

Division Chief

**Agency:**

Alabama Department of Senior Services

**Address:**

770 Washington Ave, Suite 570

**Address 2:****City:**

Montgomery

**State:**

Alabama

**Zip:**

36104

**Phone:**

(334) 242-5743

Ext:

TTY

**Fax:**

(334) 242-5594

E-mail:

jean.stone@adss.alabama.gov

## 8. Authorizing Signature

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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.

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Signature:

Ginger Wettingfeld

State Medicaid Director or Designee

Submission Date:

Sep 11, 2012

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

Last Name:

Azar

First Name:

Stephanie

Title:

Acting Commissioner

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Avenue

Address 2:

City:

Montgomery

State:

Alabama

Zip:

36103-5624

Phone:

(334) 242-5600

Ext: [ ]

TTY

Fax:

(334) 242-5097

E-mail:

Attachments

Stephanie.Azar@medicaid.alabama.gov

#### Attachment #1: Transition Plan

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable.

#### 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.*

#### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

[Large empty rectangular box for additional needed information.]

#### Appendix A: Waiver Administration and Operation

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

**The waiver is operated by the state Medicaid agency.**

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

**The Medical Assistance Unit.**

Specify the unit name:

(*Do not complete item A-2*)

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

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

(*Complete item A-2-a*).

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

Specify the division/unit name:

Alabama Department of Senior Services (ADSS)

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

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

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

The HIV/AIDS and Related Illnesses (AIDS) Waiver is administered by the Long Term Care Division of the Alabama Medicaid Agency (AMA) and operated by the Alabama Department of Senior Services (ADSS).

The Medicaid Agency exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The Medicaid Agency assumes the responsibility of:

- 1) Ensuring that providers meet all provider standards.
- 2) Conducting joint trainings with direct service providers enrolled to provide services through the AIDS Waiver program.
- 3) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the AIDS Waiver program. These policies are outlined in the AIDS Waiver manual.
- 4) Conducting annual training to disseminate policies, rules and regulations regarding the home and community based waiver programs.

The ADSS is the operating Agency for the AIDS waiver and is delegated the responsibility by the AMA of:

Providing participants with free choice of providers and waiver service workers,

Ensuring all direct service providers meet the qualifications as outlined in the waiver document,

Ensuring the health and welfare of participants,

Improving care received by participants, and

Ensuring program compliance with the waiver document and the requirements of the AMA.

ADSS works collaboratively with the AMA to conduct an annual quality assurance review to ensure that the process and instruments described in the approved waiver are applied. When deficiencies are noted a plan of correction is requested by AMA staff so that recommendations made by AMA as a result of the quality assurance reviews are addressed by ADSS and the Direct Service Providers (DSP).

Reviews of participant files, personnel files, and home visits are methods the state uses to monitor compliance with level of care determinations, appropriateness of the plan of care, that qualified providers are rendering services in accordance with the waiver document so that the health and welfare of the participant is ensured. The reviews also ensure that participants are informed and knowledgeable about the complaint and grievance process and that ADSS has a process in place to address, track and resolve complaints and grievances.

The state has also developed a Quality Management Strategy for the AIDS Waiver.

The following activities are components of the Quality Management Strategy:

1. Collect ongoing monthly data to monitor appropriateness of level of care determinations. A 10% random monthly retrospective review is performed by an AMA nurse reviewer.
2. Quarterly data is collected by registered nurses reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participants homes and conducting consumer satisfaction surveys, and tracking complaints and grievances.
3. Remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.
4. Data collected is reported quarterly and annually to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

## Appendix A: Waiver Administration and Operation

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

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- 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:

## Appendix A: Waiver Administration and Operation

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- 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:

## Appendix A: Waiver Administration and Operation

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

## Appendix A: Waiver Administration and Operation

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### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

##### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

Number and percent of critical incidents investigations completed within time frames specified in the agreement with the Medicaid Agency

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data	Sampling Approach( <i>check</i>
----------------------------	-------------------	---------------------------------

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of service plans for new enrolles completed in time frame specified in the agreement with the Medicaid Agency**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (<i>check each that applies</i>):</b>	<b>Frequency of data aggregation and analysis(<i>check each that applies</i>):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  _____	Annually

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

**Performance Measure:**

**Number and percent of quality assurance record reviews conducted each month as compared to what was specified in the agreement with the Medicaid Agency**

**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

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**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  _____
Other Specify:  _____	Annually	Stratified Describe Group:  _____
	Continuously and Ongoing	Other Specify:  10% _____
	Other Specify:  _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  [Redacted]	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  [Redacted]

**Performance Measure:**

**Number and percent of provider agreements/contracts that adhered to the states uniform agreement/contract requirements**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  [Redacted]	Annually
	Continuously and Ongoing
	Other Specify:  [Redacted]

**Performance Measure:**

**Number and percent of LOC determinations completed in time specified in the agreement with the Medicaid Agency.**

**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
State Medicaid Agency	Weekly	<b>100% Review</b>
Operating Agency	Monthly	<b>Less than 100% Review</b>
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
Other Specify:  <input type="text"/>	Annually	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	Other Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  [Redacted]	Annually
	Continuously and Ongoing
	Other Specify:  [Redacted]

**Performance Measure:**

Number and percent of provider reviews conducted with the frequency required in the agreement with the Medicaid Agency

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>
Other Specify:  <input type="text"/>	Annually	Stratified Describe Group:  <input type="text"/>
	Continuously and Ongoing	Other Specify:  <input type="text"/> 10%
	Other Specify:	

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**Data Aggregation and Analysis:**

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

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

The Alabama Medicaid Agency (AMA) exercises administrative authority and responsibility of all waiver related policies and the OA's adherence to rules and regulations governing the HIV/AIDS Waiver. AMA conducts annual training to disseminate policies, rules and regulations in an effort to ensure consistent application of the policies related to the HIV/AIDS Waiver program. The Commissioner of the AMA signs all direct service contracts of qualified providers enrolled with the OA every 3 years to ensure quality waiver services are provided.

AMA reviews participant files, personnel files and performs home visits (as needed) as a method to monitor compliance in:

- The level of care determination process;
- The appropriateness of the plan of care; and
- The monitoring of services to ensure quality care is provided by providers contractyed with the OA.

**b. Methods for Remediation/Fixing Individual Problems**

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

AMA LTC Division is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the HIV/AIDS Waiver program. The Quality Framework is used as a guide to assess seven Program Design Focus areas: samples of waiver participants, case management and direct service providers' records, and on-site home visits when deemed necessary. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-traced with targeted surveys to determine participants' satisfaction with resolutions.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants records approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the participant are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. AMA LTC Division will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are to be made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

#### Participant Access

Sources of data:

- Case Management Records
- Home Visits
- DSS Queries
- Consumer Surveys

#### ParticipantCentered Service Planning and Delivery

Sources of data:

- Consumer Surveys
- Case Management Records
- Site Visits
- Home Visits

#### Provider Capacity and Capabilities

Sources of data:

- Consumer Surveys
- Case Management Records
- Personnel and Training Records of Operating Agency and Subcontractors
- Home Visits

#### Participants Safeguards

Sources of data:

- Case Management Records
- Consumer Surveys
- Home Visits
- Site Visits

**Participants Rights and Responsibilities**

Sources of data:

- Consumer Surveys
- Case Management Records
- Complaint and Grievances Logs
- Targeted Surveys

**Patient Satisfaction**

Sources of data:

- Consumer Surveys
- Case Management Records
- Home Visits
- Site Visits

**System Performance**

Sources of data:

- Review of Operating Agency Quality Assurance System
- Review of Operating Agency Billing and Service Provision
- Collaborative Meeting with Operating Agency to enhance the administration of the Program
- Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaids Long Term Care Division:

Percentage of participant/family reporting satisfaction with waiver services and needs met.

Percentage of participant/family reporting they feel safe and secure in the home and community.

Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.

Percentage of participant/family reporting knowledge of rights and responsibilities.

Percentage of records indicating services are planned and implemented according to the participants needs and preferences.

Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.

Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants records approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the participant are being met, and to gain input about the quality of the services received.

**ii. Remediation Data Aggregation**

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

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS	21	<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Developmental Disability			
		Intellectual Disability			
<b>Mental Illness</b>					
		Mental Illness			
		Serious Emotional Disturbance			

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

The AIDS Waiver also provides services to individuals with HIV/AIDS and related illnesses who meet the nursing facility level of care.

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

**Not applicable. There is no maximum age limit**

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

**No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

**Other**

*Specify:*

[Redacted]

**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.*

[Redacted]

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

**The following dollar amount:**

Specify dollar amount: [Redacted]

**The dollar amount (select one)**

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

Specify the formula:

[Redacted]

**May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

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

Specify percent: [Redacted]

**Other:**

Specify:

[Redacted]

## Appendix B: Participant Access and Eligibility

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

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

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- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

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

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

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

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

**The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

**Appendix B: Participant Access and Eligibility****B-3: Number of Individuals Served (2 of 4)**

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

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

**The state reserves capacity for the following purpose(s).**

**Appendix B: Participant Access and Eligibility****B-3: Number of Individuals Served (3 of 4)**

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

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

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

The state provides entrance to the waiver for all eligible persons with a diagnosis of HIV/AIDS and Related Illnesses who meet the nursing facility level of care and who meet the financial criteria for waiver eligibility.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

**§1634 State**

**SSI Criteria State**

**209(b) State**

- 2. Miller Trust State.**

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

**No**

**Yes**

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

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

**Low income families with children as provided in §1931 of the Act**

**SSI recipients**

**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

**Optional state supplement recipients**

**Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one:*

**100% of the Federal poverty level (FPL)**

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

Specify percentage:

**Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)**

**Working individuals with disabilities who buy into Medicaid (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)**

**Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state**

plan that may receive services under this waiver)

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.135, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals deemed eligible for AFDC under 42 CFR 435.145 and 435.227.

---

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

---

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without 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)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

--

## Appendix B: Participant Access and Eligibility

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

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

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

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

**The following standard included under the state plan**

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(*select one*):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

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

**Other**

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

iii. Allowance for the family (select one):

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

*Specify:*

---

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

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

Select one:

**Not Applicable (see instructions)** Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

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

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

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

---

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

---

## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

**i. Minimum number of services.**

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

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

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By 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:

A nurse reviewer employed by the ADSS is responsible for performing the level of care determination. The Nurse Reviewer is a registered nurse with an active license issued by the Alabama Board of Nursing.

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



The HIV/AIDS Waiver program serves recipients that meet the nursing facility level of care. At least two (2) of the following nursing facility level of care criteria must be met for initial determinations and re-determinations to be able to evaluate and reevaluate applicants and recipients for waiver services:

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

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

If an individual meets one or more ADL deficits within criterion (k), they must also meet an additional criterion, (a) through (j), accompanied by supporting documentation, as is currently required. Multiple items met under (k) will still count as one criterion.

Also note, Criterion (a) is also the same as Criterion (k) 7. Therefore, if an individual meets criterion (a), criterion (k) 7, cannot be used as the second qualifying criterion.

Additionally, Criterion (g) is the same as Criterion (k) 9. Therefore, if an individual meets criterion (g), Criterion (k) 9, cannot be used as the second qualifying criterion.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The case manager performs a thorough assessment of the applicant/recipient living situation, their ability to perform activities of daily living, available community resources, support from family/others and develops a plan of care to address any gaps which place the applicant/recipient at risk for institutionalization. Medical certification is then obtained from the attending physician. Information gathered from the case manager and the attending physician is forwarded to the Nurse Reviewer at ADSS for a level of care determination. A level of care determination for an applicant/recipient is processed based upon information contained on the HCBS-1 assessment as well as physician progress notes and /or hospital records as needed or requested by the nurse reviewer. The appropriateness of placement on the waiver or the continuation of waiver services involves consideration of the aforementioned factors as well as the functional limitation of the individual, medical diagnosis, support systems in place and any other factors which place the individual at risk for institutionalization. Applicants must meet two criteria as defined in B-6. (d). At annual redetermination recipients are required to meet two criterion as defined in B-6. (d). for continued eligibility.

The AMA has granted the ADSS Nurse Reviewer the authority to make the level of care determinations. During the audits of an Operating Agency, the AMA Quality Improvement and Standards Division Nurse Reviewer may also review the application to determine if the HIV/AIDS Waiver level of care is appropriate.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

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

**The qualifications are different.**

*Specify the qualifications:*

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

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

All recipients enrolled in the HIV/AIDS waiver must have an annual re-determination of need for the nursing facility level of care to continue to qualify for services through these waivers. The first re-determination of need for the level of care is to be made within a year of the individuals initial determination.

**PROCEDURE:**

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

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

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

The operating agency may submit an early re-determination application as early as 90 days before the annual re-determination date. Applications received prior to 60 days of the annual date will be returned. All re-determinations must be completed before the LOC segment date expires.

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

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

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

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

Written and/or electronically retrievable documentation of level of care determinations and redeterminations are maintained for maximum a period of five (5) years. Case management records containing the level of care determinations are maintained by the operating agency. Additional documentation is maintained with direct services providers responsible for providing waiver services for(5)years.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

### **Quality Improvement: Level of Care**

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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.**

#### **Performance Measures**

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

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

#### **Performance Measure:**

**Number and percent of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services**

#### **Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

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

## Performance Measures

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

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

### Performance Measure:

Number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their last redetermination

#### Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	<b>100% Review</b>
Operating Agency	Monthly	<b>Less than 100% Review</b>
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly

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

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of LOC determinations made where the LOC criteria was accurately applied**

#### Data Source (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:****Number and percent of LOC determinations made by a qualified evaluator****Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of participants' level of care determinations forms/instruments that were completed as required by the state**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	<b>100% Review</b>
Operating Agency	Monthly	<b>Less than 100% Review</b>
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
Other Specify:  <input type="text"/>	Annually	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

The Alabama Medicaid Agency (AMA) has granted the OA Nurse Consultant the authority to make the level of care (LOC) determinations and annual redeterminations (reevaluations). The AMA may assist the OA with difficult LOC evaluations. On a monthly basis, AMA Long Term Care staff will run a query of all HIV/AIDS applications that are accepted into the MMIS system. The AMA LTC Division Nurse Reviewer will randomly select a percentage of applications for retrospective review. The AMA Nurse Reviewers will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes, and/or any other documentation to support the participant's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (reevaluation) must be completed every twelve months.

The process is the same as for an initial evaluation. The OA is responsible for completing the reevaluations in a timely manner, or the claim will deny.

The AMA conducts quarterly Quality Assurance meetings which includes staff from LTC and representatives from staff of the HIV/AIDS (and other waivers) waiver. These meetings are designed to inform, educate, discuss matters of concern etc.

**b. Methods for Remediation/Fixing Individual Problems**

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

The AMA conducts satisfaction surveys on a quarterly basis. The survey is sent to a random sample of participants/representatives. The purpose of the survey is to evaluate the participants satisfaction with the waiver services. Any adverse responses are tracked through to a resolution either by the OA or AMA, depending upon the issue. A targeted satisfaction survey is sent out (within 45 days of receipt) as a follow-up to assure the clients satisfaction with the resolution. Results of satisfaction surveys are totaled in percentages using a bar graph. On a quarterly basis the results are sent to the OA. Additionally, the OA is responsible for keeping a log of complaints/grievances that must be tracked through to a resolution. Grievances will be resolved within 45 days of receipt by the DSP, OA, or AMA. Grievances are to be resolved in an appropriate and timely manner. If the grievances are not resolved to the satisfaction of the participant or AMA, the OA will be asked to submit a Plan of Correction to resolve the grievance to the participants satisfaction, if possible, or to ensure prevention of re-occurrence. If the grievance is not resolved within 45 days, AMA may assist the OA in reaching a satisfactory resolution. In no instance will grievance resolution exceed 90 days of receipt. The OA will be notified of any complaints/grievances received by AMA involving the OA or any of its providers of care within two working days of receipt. Responses of dissatisfaction are addressed with the HIV AIDS Case Manager who provides follow-up with the participant within three working days and reports findings and resolution to the state office within 30 days of notification. All waiver participants sign a Complaint/Grievance Policy and Procedure form at the time of initial application and re-evaluation that provides them with the avenue to reach resolution of any problems. This form provides the contact information for the HIV/AIDS Coordinator at the OA where participant's may lodge complaints at any time. The State Office will notify the HIV/AIDS Case Manager within three working days of the complaint. The HIV/AIDS Case Manager will follow-up on the complaint within three days from the State Office notification. The HIV/AIDS Case Manager will report resolution to the State Office within 30 days of notification of complaint.

HIV/AIDS Nurse Reviewers at the AMA will review a random selection of 10% of waiver participants records annually to ensure compliance with the waiver document and participant satisfaction with service. Satisfaction of services is reviewed during the monthly home visits and documented in the participant record.

## ii. Remediation Data Aggregation

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

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

## c. Timelines

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

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

The case manager, employed by the operating agency, verbally informs eligible individuals or their legal representatives of the feasible alternatives available under the waiver, allowing free choice of waiver services or institutional care, during the assessment/application process for admission, readmission, and redetermination of eligibility. Participants and/or their representative are given as much information as possible to allow them to make an informed choice based upon their individual and personal preferences without putting their health and safety at risk. This information is also provided in writing. The applicant/recipient or their legal representative signs the freedom of choice statement on the Admission and Evaluation Data form (HCBS-1, page 3) which serves as documentation of the individual's choice. The only exception to a written choice is when the participant is not capable of signing the form. The reason for the absence of the signed choice form must be documented in the participant's case record. If the participant has a legal representative that individual may sign the choice form.

- 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.

Freedom of Choice forms are maintained in the Operating Agency's case record for a minimum of five years.

## Appendix B: Participant Access and Eligibility

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

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

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents.

The language translation line offers numerous languages that applicants/participants may access through the Medicaid toll free telephone number. Translators on the language line can assist the LEP applicant/participant to request and receive any available Medicaid assistance and apply for available Medicaid services.

The Medicaid Agency website also contains a link to AltaVista Babel Fish Translation. This tool enables individuals with limited English proficiency to translate short passages of text or entire web sites among 19 pairs of languages. Babel Fish allows users to grasp the general intent of the original message and does not produce a polished translation.

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite		
Other Service	Companion Services		
Other Service	Skilled Nursing		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

**Service Definition (Scope):**

Case Management(CM)is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services. CM Service may be used to locate, coordinate, and monitor necessary and appropriate services. CM activities can also be used to assist in the transition of an individual from institutional settings such as hospitals and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible. Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. CM is a waiver service available to all HIV/AIDS (AIDS) Waiver clients. Case Managers assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available, and desired by the client.

A unit of service will be fifteen (15) minutes beginning on the date that the client is determined eligible for AIDS Waiver Services and is entered into the Medicaid Long Term Care (LTC) file. CM services provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required monthly in addition to any other CM activities.

For transitional CM a unit of service that assists individuals transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During the transitioning period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor.

Within the context of home and community-based services, CM may include, but is not limited to, the following functions:

- a. Conducting assessments of need and necessity for waiver services;
- b. Completing and processing level of care applications for admission, readmission or redetermination of eligibility;
- c. Developing, monitoring, and revising the client's Care Plan in coordination with the client/caregiver;
- d. Arranging and authorizing waiver services according to the client's Care Plan;
- e. Making referrals and assisting clients to gain access to needed Medicaid State Plan and other non-waiver services;
- f. Coordinating the delivery of waiver and non-waiver services included in the client's Care Plan;
- g. Monitoring the quality and effectiveness of waiver and non-waiver services provided to the client;
- h. Making at a minimum, a monthly face-to-face visit with every active waiver client to monitor the Plan of Care;
- i. Monitoring the cost-effectiveness of waiver services for an individual;
- j. Processing transfers from county-to-county or from:
  - k. Facilitating transfers to or from other home and community-based waiver programs; and
  - l. Transitioning clients who meet the nursing facility level of care from institutional settings such as hospitals and nursing facilities.
- m. Reinstating AIDS Waiver Services following a client's short-term nursing home stay;
- n. Processing terminations of waiver eligibility and services;
- o. Establishing and maintaining case records.

Prior to waiver approval, all potential clients are screened by the CM to access their potential eligibility and to determine their desire for waiver participation. The intake screening activities and eligibility determination are distinct from Direct Case Management but are included in this scope of service since they are preliminary activities necessary for waiver enrollment. With the exception of case management activities for individuals transitioning from an institution into the community, Case Management activities provided to a client prior to waiver approval is considered administrative. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Operating Agency must have a Quality Assurance Program for Case Management Service in place and approved by the Alabama Medicaid Agency. The Quality Assurance Program shall include Case Manager record

reviews at a minimum of every sixty (60) days. Documentation of quality assurance reviews and corrective action must be maintained by the Operating Agency and will be subject to review by the Alabama Medicaid Agency.

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

The amount, frequency or duration of this service is dependent upon the participant's needs as set forth in the Plan of Care for regular waiver case management. There is a maximum limit of 180 working days under the HCBS waiver to assist an individual to transition from an institutional setting to a community setting. During this 180 day time frame the case manager must make a minimum of 3 face-to-face visits and have monthly contact with the client or the client's sponsor.

In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the development of the care plan or from signing the service authorization log.

If a conflict of interest does arise due to a family member being a direct service provider, the State will ensure that another individual be assigned the responsibilities of participating in the plan of care development and signing the service authorization log if the recipient is unable to do so. The ADSS Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

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**Service Name: Case Management**

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**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications**

**License (specify):**

State of Alabama

**Certificate (specify):**

--

**Other Standard (specify):**

License must be current

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Board of Nursing and ADSS

**Frequency of Verification:**

Verified Annually and Bi-annually

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## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Case Management**

---

**Provider Category:**

Individual

**Provider Type:**

Social Worker

**Provider Qualifications**

**License (specify):**

Social Work

**Certificate (specify):**

--

**Other Standard (specify):**

Earned a degree from an accredited School of Social Work

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ADSS

**Frequency of Verification:**

Verified initially and bi-annually thereafter

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## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Case Management**

---

**Provider Category:** Individual**Provider Type:** Bachelor of Arts or Bachelor of Science Degree**Provider Qualifications****License (specify):** None**Certificate (specify):** None**Other Standard (specify):** Preferably in a human services related field from an accredited college or university Training in Case Management curriculum approved by the Alabama Medicaid Agency and the Case Management service provider. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by the Alabama Medicaid Agency and attend on-going training and in-service programs deemed appropriate.**Verification of Provider Qualifications****Entity Responsible for Verification:** ADSS**Frequency of Verification:** Verified initially

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**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:** Statutory Service**Service:** Homemaker**Alternate Service Title (if any):****HCBS Taxonomy:**

**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

The Homemaker Service(HM) provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, writing and mailing checks but not signing them.

Homemaker Services are designed to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the HIV/AIDS (AIDS) waiver. A unit of service is fifteen (15) minutes of direct Homemaker Service provided in the clients residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemakers transportation time to or from the clients residence, or the Homemakers break or mealtime.

Homemaker Services duties include, but are not limited to, the following:

- a. Meal or snack preparation, meal serving, cleaning up afterwards;
- b. General housekeeping which includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
- c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;
- d. Assistance with paying bills which includes opening bills, writing checks but not signing them and delivering payments to designated recipients on behalf of the client;
- e. Assistance with communication which includes placing phone within clients reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;
- f. Observing and reporting on clients condition;
- g. The homemaker is not allowed to transport the client by vehicle in the performance of their task.
- h. Reminding clients to take medications

Under no circumstances should any type of skilled medical or nursing service be performed by the Homemaker Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The DSP completes a supervisory review every sixty (60) days which includes, at a minimum, assurance that services are delivered and consistent with the POC and the service authorization form in an appropriate manner, assurance that the clients needs are being met, and a brief statement regarding the clients condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review.

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

The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. While there are no set limits on the amount frequency, or duration of this service it is not available 24 hours per day.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Care Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

Business

**Certificate (specify):**

N/A

**Other Standard (specify):**

The Homemaker must complete a training program prior to initiation of service with the client that is provided and/or

conducted by the Direct Service Provider.

The Homemaker must have at least (6) hours, in-service training annually.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Alabama Department of Senior Services

**Frequency of Verification:**

Annual upon initial approval and biannually thereafter if no compliance concerns exist.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :***Service is included in approved waiver. There is no change in service specifications.****Service is included in approved waiver. The service specifications have been modified.****Service is not included in the approved waiver.****Service Definition (Scope):**

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently. The unit of service will be fifteen (15) minutes of direct PC Service provided in the clients residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the clients residence or the Personal Care Worker's break or mealtime.

THe PC Service duties include:

- a. Support for activities of daily living, such as, bathing, personal grooming, personal hygiene, meal preparation, assisting clients in and out of bed, assisting with ambulation, toileting and/or activities to maintain continence
- b. Home support that is essential to the health and welfare of the recipient, such as, cleaning, laundry and home safety. Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the case manager for follow-up.
- c. Reporting observed changes in the client's physical, mental or emotional condition.
- d. Reminding clients to take medication.
- e. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The PCW is not allowed to transport clients. Under no circumstances should any type of skilled medical or nursing service be performed by the PCW. Medicaid will not reimburse for activities performed which are not within the scope of service.

The DSP must complete a supervisory review every sixty (60) days which includes, at a minimum, assurance that the services are being delivered consistent with the POC and the service authorization form in an appropriate manner, assurance that the clients needs are being met, and a brief statement regarding the clients condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.

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

The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. While there are no set limits on the amount frequency, or duration of this service it is not available 24 hours per day.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Care Agency or Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Personal Care**

**Provider Category:**

Individual

**Provider Type:**

Home Care Agency or Home Health Agency

**Provider Qualifications**

**License (specify):**

Business

**Certificate (specify):**

Certificate of Need(CON)if the provider type is a Home Health Agency.

**Other Standard (specify):**

Waiver of Certificate of Need approved by the Medicaid Commissioner.

The personal care worker must have training prior to initiation of service with a client provided by the Direct Service

Provider (DSP).

The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year to each worker.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Alabama Department of Senior Services (Operating Agency)

**Frequency of Verification:**

Annually upon initial approval and biannually thereafter if no compliance concerns exist.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :***Service is included in approved waiver. There is no change in service specifications.****Service is included in approved waiver. The service specifications have been modified.****Service is not included in the approved waiver.****Service Definition (Scope):**

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the clients household. Respite Care is not an entitlement. The Respite Care service is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

Respite Care is intended to supplement, not replace care provided to waiver clients. Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely due to the unavailability or absence of the primary caregiver. The unit of service is fifteen minutes (15) of direct Respite Care provided in the clients residence. The amount of time does not include the Respite Care Workers (RCW) transportation time to or from the clients residence or the Respite Care Worker's break or mealtime.

Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.

(a) Orders from the clients physician(s) are obtained before service implementation, annually and when changes occur.

(b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.

In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:

(a) Assistance with activities of daily living (ADLs), such as, bathing, personal hygiene and grooming, dressing, toileting or activities to maintain continence, preparing and serving meals or snacks and providing assistance with eating, transferring and ambulation.

(b) Home support that is essential to the health and welfare of the recipient, such as, cleaning, laundry, assistance with communication and home safety. Home safety includes a general awareness of the homes surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.

(c) Skilled nursing services as ordered by the clients physician, including administering medications.

(d) Skilled medical observation and monitoring of the clients physical, mental or emotional condition and the reporting of any changes.

(e) Orienting the client to daily events.

Unskilled Respite Services will provide and/or assist with activities of daily living and observations. In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:

a. Meal or snack preparation, meal serving, cleaning up afterwards;

b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;

c. Assistance with communication which includes placing the phone within clients reach and physically assisting client with use of the phone and orientation to daily events;

e. Support for activities of daily living, such as , bathing, personal grooming, personal hygiene, assisting clients in and out of bed, assisting with ambulation, toileting and/or activities to maintain continence;

f. The Respite Care worker will ensure that the client is residing in a safe environment. any concerns with safety issues will be reported to the RCW Supervisor as well as the Case Manager for follow-up;

g. Reporting observed changes in the client's physical, mental or emotional condition;

h. Reminding clients to take medication.

Under no circumstances should any type of skilled medical or nursing service be performed by an Unskilled Respite Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Skilled and Unskilled Respite Supervisor will provide on-site (clients residence)supervision of the Skilled and Unskilled Respite Care Worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the Operating Agency. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by Skilled or Unskilled Respite Care Worker.

The Skilled and Unskilled Respite Supervisor will provide on-site (clients residence)supervision of the Skilled and Unskilled Respite Care Worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the Operating Agency. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by Skilled or Unskilled Respite Care Worker.

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

The number of units and services provided to each client is dependent upon the individual clients need as set forth in the clients POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 720 hours (2880 units) per waiver year (October 1-September 30) in accordance with the provider contracting period.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Care Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

Business/ Active Licensed Practical Nurse license or Registered Nurse license from the Alabama Board of Nursing

**Certificate (specify):**

N/A

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:** Alabama Department of Senior Services (Operating Agency) and AMA Waiver Quality Assurance Unit.**Frequency of Verification:** Annually upon initial approval and biannually thereafter if no compliance concerns exist.**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:** Other Service

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

**Service Title:** Companion Services**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

**Service Definition (Scope):**

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

The Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the HIV/AIDS Waiver.

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

Companion Service includes:

- a. Supervision/observation of daily living activities, such as, reminding client to bathe and take care of personal grooming and hygiene, reminding client to take medication, observation/supervision of snack, meal planning and preparation, and/or eating; and toileting or maintaining continence.
- b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.
- c. Supervision/assistance with laundry.
- d. Performance of housekeeping duties that are essential to the care of the client
- e. Assist with communication.
- f. Reporting observed changes in the clients physical, mental or emotional conditions.

Under no circumstances should any type of skilled medical or nursing service be performed by the Companion Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Companion Worker Supervisor will provide on-site supervision at the clients place of residence at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record and a copy placed in the individuals personnel file.

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

The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. Companion service is available only to those clients who reside alone. While there are no set limits on the amount frequency, or duration of this service, it is not available 24 hours per day.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Care Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Companion Services**

**Provider Category:**

Individual

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

Business

**Certificate (specify):**

N/A

**Other Standard (specify):**

Companion Workers must complete a minimum training program prior to initiation of service with a client provided and/or conducted by the Direct Service Provider.  
All workers must have at least six (6) hours in-service training annually.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Alabama Department of Senior Services (Operating Agency)

**Frequency of Verification:**

Annually upon initial approval and biannually thereafter if no compliance concerns exist.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Skilled Nursing

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

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

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Skilled nursing under the waiver will not duplicate skilled nursing under the home health benefit in the state plan. Skilled Nursing Services are not an entitlement.

The Skilled Nursing Service is to provide skilled medical monitoring, direct care, and intervention for the individual with HIV/AIDS to maintain him/her through home support. This service is necessary to avoid institutionalization.

A unit of service is fifteen (15) minutes of direct skilled nursing care provided in the client's home. The number of units authorized per visit must be stipulated on the Plan of Care (POC) and Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the skilled nursing workers break or mealtime.

The Skilled Nursing Service duties include:

- (a) Administering medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist.
- (b) Additional acts requiring appropriate education and training designed to maintain access to a level of health care for the consumer may be performed under emergency or other conditions, which are recognized by the nursing and medical professions as proper to be performed by a Registered Nurse or LPN.

The Skilled Nursing Service administers skilled services as ordered by the physician, evaluates the effectiveness of these services, and report changes in conditions as warranted. Medicaid will not reimburse for activities performed which are not defined within the scope of services.

The Skilled Nursing Service Supervisor will provide on-site supervision at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the LPN.

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

This service must not duplicate skilled nursing under the mandatory home health benefit in the state plan. If a waiver client meets the criteria to receive the home health benefit, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Care Agency

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Skilled Nursing**

**Provider Category:**

Individual

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

A business license is required for the home care agency. Registered Nurses or Licensed Practical Nurses employed by the home care agency must have a current license from the Alabama State Board of Nursing

**Certificate (specify):**

N/A

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Home Care Agency

**Frequency of Verification:**

Annual upon initial approval and biannually thereafter if no compliance concerns exist.

## Appendix C: Participant Services

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

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

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

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

*Check each that applies:*

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

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

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

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

**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: Participant Services

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

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

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

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

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

Background checks will be required for direct service provider employees who operate within the State of Alabama and who either provide direct services to the participant and/or who have access to client records. The state background checks will be conducted by the provider agency and will also include a reference check with previous employers and the Nurse/Aid Registry. Verification of investigations will be conducted during periodic audit reviews of the service providers by the OA.

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

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

## Appendix C: Participant Services

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

**Note:** Required information from this page (Appendix C-2-c) is contained in response to C-5.

## Appendix C: Participant Services

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

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

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

**Self-directed**

**Agency-operated**

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

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

[Redacted]

**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.

[Redacted]

**Other policy.**

Specify:

Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relative or friends as providers only in return for personal care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

The State will ensure that no conflict of interest occurs by prohibiting the relative who is the direct service provider from participating in the development of the care plan or from signing the service authorization log.

If a conflict of interest does arise due to a family member being a direct service provider, the State will ensure that another individual be assigned the responsibilities of participating in the plan of care development and signing the service authorization log if the recipient is unable to do so. The ADSS Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

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

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

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

After the contract is finalized, the provider is mailed a confirmation letter. Potential providers may also view enrollment information, rules, and regulations on [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov). All willing and qualified providers are given an opportunity to enroll as an waiver provider.

If a provider wishes to contract directly with Medicaid, the Operating Agency will perform the preliminary functions (waiver & provider requirements, scopes of services, policies & procedures etc.) The Operating Agency will forward the information to Medicaids Waiver Program Manager to enroll directly with the Agency. The Medicaid Program Manager will notify the provider of the process and direct them on how to apply for an NPI number. Once the provider has the NPI number, they may complete the enrollment application on [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### a. Methods for Discovery: Qualified Providers

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of agency providers whose direct support staff had timely criminal background and registry checks**

#### Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  [Redacted]	<b>Annually</b>

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

**Performance Measure:**

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

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**Via Medicaid's Fiscal Agent**

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

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

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of new provider applications for which appropriate background and registry checks, as required by the state/waiver, were conducted**

**Data Source (Select one):**

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of providers, by provider type, continuing to meet applicable licensures/certification following initial enrollment**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Via Medicaid's Fiscal Agency**

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

**Data Source** (Select one):**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

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

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

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

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

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

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

**Performance Measure:**

Number and percent of providers, by provider type, meeting provider training requirements

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

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

The Alabama Medicaid Agency (AMA) has granted the Operating Agency authority to determine the qualifications of providers. The AMA reviews annually the Operating Agency's training documentation for compliance with state requirements.

The AMA conducts quarterly Quality Assurance meetings which includes staff from LTC and representatives from staff of the HIV/AIDS (and other waivers) waiver. These meetings are designed to inform, educate, discuss matters of concern, etc.

The AMA employs Nurses Reviewers that conduct monthly and quarterly reviews of admissions and reevaluations. Satisfaction Surveys and critical incidents reports are also reviewed by AMA.

#### **b. Methods for Remediation/Fixing Individual Problems**

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

The AMA LTC Division is available to assist the Operating Agency as needed. If problems arise, AMA will send a letter to the OA addressing the issue(s) at hand and require a response as to their follow-up plan of correction and corrective measures to resolve any/all problems found.

#### **ii. Remediation Data Aggregation**

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

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

#### **c. Timelines**

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

**No**

**Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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

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

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

**Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

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.*

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Plan of Care (POC)

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

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

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## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The case manager, the client and/or a family or legal representative or other persons designated by the client all meet to develop the plan of care. During the meeting all parties discuss the needs of the client, informal supports provided by family or other community resources, identify the gaps in supports and are informed of what waiver services may fill in those gaps. The participant decides which personal representative will be involved in development of the plan of care.

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## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant-centered plan of care is developed collaboratively with the client, case manager, family or legal representative, if applicable, and other persons designated by the client. The plan of care is developed as a part of the initial assessment for all applicants for waiver services and revised periodically as the recipients needs change.

The case manager schedules a meeting with all interested parties to secure information about the client's needs, preferences, goals, other non waiver services or community supports. The case manager completes the a needs assessment to assist with the development of the plan of care. The client and/or their family member or legal representative is informed of services available through the waiver. Medical information obtained from the client's primary physician is considered in development of the plan. The care plan is then developed and based upon the client's functional capacity, limitations, health care needs, formal and informal supports from the family, caregiver(s) and community. Care plans are individualized for each participant and seek to balance the client's rights, values, and preferences.

When the plan of care is developed, with the necessary waiver services to fill in gaps in care, the client is given a choice of qualified and willing providers of waiver services. The client/and or their family or legal representative must complete a freedom of choice form to document they were given a choice of qualified providers of waiver services. The amount, duration and frequency of all waiver services are documented in the plan of care to avoid duplication of services and to establish complete coordination of care. Services contained in the plan of care represent services that will provide supports necessary for the client to remain safely in the home. The case manager completes a service authorization form which is forwarded to the direct service provider to ensure services are provided in accordance with the plan of care.

The care plan is monitored monthly during the case manager's face to face visit, at redetermination annually, and more frequently if the client's condition warrants modification of the care plan. When a plan of care is revised, as warranted by changes in the client's condition, the client/and or their family member or legal representative must be issued a written notice at least 10 days in advance of any adverse actions that may result from the change.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Potential risks to participant's safety are addressed in development of the plan of care. In addition during the monthly face-to-face case management visit, the participant's health and welfare is reviewed, the plan of care adjusted accordingly and evaluated for appropriateness. During the monthly visit the case manager assesses the home to ensure the participant is safe, questions the participant as well as makes observations to ensure the health needs are met, notes any changes that may require modifications to the POC. The case manager also documents, addresses and monitors any health and safety concerns.

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

Additionally, Direct Service Provider (DSP) staff visit the participants home as ordered in the plan of care. DSPs are trained and expected to observe and report any concerns about a participants health and welfare to the case manager and in writing to supervision of the DSP Agency. When health and safety concerns are noted the case manager will schedule a home visit as soon as possible to further assess/monitor, provide any intervention and follow-up. Case managers will review and modify the POC if necessary to address the concerns.

Waiver applicants/recipients are also informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

At application, redetermination and when the plan of POC is modified participants are given a choice of qualified and willing providers of AIDS Waiver services that are included in the plan of care. A form is signed by the participant to indicate they were given freedom of choice of vendors to provide waiver services at initial application and annually at redetermination.

The freedom of choice list is given to the participant/caregiver which contains a list of all enrolled DSP of AIDS waiver services in their area. The list also includes the services the DSP is approved to provide. The participant then ranks the providers by choice with a minimum of three providers chosen or more if the participant chooses to select additional providers. The participant can also indicate no preference of DSP. In this instance the case manager assigns a provider based upon DSP availability and participant services contained in the POC. The freedom of choice provider list form kept in the participants record to evidence individual choice. The participant can change providers at any time by notifying the case manager. It is important that the client, responsible party, and/or significant other make this decision independently, and the case manager is cautioned not to influence a client's choice of providers.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Medicaid Agency performs a retrospective review of a random sample of approved applications on a monthly basis. The purpose of this review is to ensure compliance with both state and federal guidelines. During this review process the service plan is subject to the approval of the Medicaid Agency.

The Medicaid Agency Quality Assurance division also conducts an annual review of the Operating Agency. During the annual audit a random sample of approved waiver applications are reviewed to ensure compliance. Service plans are reviewed during the audits and are subject to approval of the Medicaid Agency.

If discrepancies relating to the service plan or compliance with other state and federal guidelines are identified during either review the Operating Agency is notified in writing, has an opportunity to resolve or clarify the discrepancies, or provide a plan of correction. Results of the audit may result in recoupment of funds.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

[Redacted]

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

Medicaid agency

Operating agency

Case manager

Other

*Specify:*

[Redacted]

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-2: Service Plan Implementation and Monitoring**

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

The entity responsible for monitoring the implementation of the service plan and for monitoring participant health and welfare is case management staff employed by the Alabama Department of Senior Services.

When a client has been approved for AIDS Waiver services and the POC implemented or when changes are made to the plan of care the case manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services, included in the plan of care.

The case manager should discuss the following with the DSP:

- 1) Coordination of the services contained in the Plan of Care (POC);
- 2) The participant's general condition and needs; and
- 3) The AIDS Waiver services/tasks and frequency the services/tasks are to be provided.

The case manager must obtain a verbal approval or refusal to provide AIDS Waiver services from the DSP. If the DSP agrees to provide services a service authorization form is completed and forwarded to the DSP along with a copy of the Home and Community Based Services application. The case manager must ensure that AIDS Waiver services requested on the service authorization include only those services contained in the approved POC. The DSP must receive documentation regarding the specific needs and desires of the client and the specific tasks to be performed. Information included on the service authorization must be clear, specific, accurate and include the number of units or hours of the service per day and the number of days per week which are authorized.

The service authorization will remain in effect until:

- 1) The case manager takes action to terminate the AIDS Waiver services requested from the DSP; or
- 2) The authorization is updated upon completion of the annual recertification even when there are no changes to participant information or AIDS Waiver services; or
- 3) The case manager is notified by the DSP of their inability to provide the authorized services.

Monitoring the POC, which is the basis of the service authorization form, validates the need for continuing each authorized service as well as provides evidence that the current POC minimizes the level of risk to the client, thus ensuring the participants health and safety.

The health and welfare of AIDS Waiver participants is monitored through periodic review of the POC. During the monthly face-to-face case management visit, the participants health and welfare is reviewed and evaluated for appropriateness and the POC adjusted accordingly.

During the home visit, case management staff of ADSS will:

- 1) Assess the home to ensure safety,
- 2) Question the participant as well as observe the home to ensure that the health needs of the participant are met,
- 3) Note any changes that may require modifications to the POC, and
- 4) Document, address and monitor any health and safety issues.

When health and safety concerns are noted the case manager will schedule a home visit as soon as possible to further assess/monitor, provide any intervention and follow-up. A home visit to monitor health and safety is required as soon as it can be arranged.

DSP staff will visit the participants home as authorized in the plan of care. DSPs are trained and expected to observe and report any concerns in a participants health and welfare to the case manager and in writing to the supervisor of the DSP Agency. The Supervisor of the DSP agency has a responsibility to contact case management staff immediately by telephone when services cannot be provided to an at risk participant. When DSP staff shortages can potentially result in a missed visit to an at risk participant's home, this participant is given staffing priority.

At anytime the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP shall contact the case manager to discuss authorization of additional services. Case management staff will review and modify the POC if necessary to address any of the aforementioned concerns.

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

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

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of service plans that address participants' goals as indicated in the assessment**

#### Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10%
	<b>Other</b> Specify:  _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  _____	Annually
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  _____

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs as indicated in the assessment**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		<b>Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of participant experience/satisfaction survey respondents who reported unmet needs**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of participants reviewed whose service plans had adequate and appropriate strategies to address their health and safety risks as indicated on the assessment**

**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Annually	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	Continuously and Ongoing	<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	<b>Other</b> Specify:	

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**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>
Other Specify:  <input type="text"/>	Annually	Stratified Describe Group:  <input type="text"/>
	Continuously and Ongoing	Other Specify:  <input type="text"/> 10%
	Other Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly

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

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of service plans where development was achieved timely as indicated in the waiver document**

#### Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of service plans that provide assignment of responsibilities to implement and monitor the plan**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly

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

**Performance Measure:**

**Number and percent of service plan development activities that are completed as described in the waiver application in Appendix D-1d: "Service Plan Development Process."**

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10%
	<b>Other</b> Specify:  _____	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:  <input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of service plans that coordinate waiver services with non-waiver services**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of service plans that included the participation of all individuals identified in the waiver document**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  [Redacted]	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  [Redacted]

**Performance Measure:**

**Number and percent of service plans that have been developed by the appropriate individual as identified in the waiver document**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>    
	<b>Other Specify:</b>    	

**Data Aggregation and Analysis:**

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

**Performance Measure:****Number and percent of service plans that follow state requirements****Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid	Weekly	100% Review

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of participant survey respondents reporting they received all the services in their plan**

#### Data Source (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10%
	<b>Other</b> Specify:  _____	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:  <input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of service plans that were reviewed, and revised as warranted, on or before waiver participants' annual review date**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of waiver participants reviewed whose service plans were revised, as needed, to address changing needs**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of participants' reviewed who received services in the type, amount, frequency and duration specified in the service plan**

#### Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of participants reviewed whose records indicated they were offered a choice of the service options included in the approved waiver**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	<b>100% Review</b>
Operating Agency	Monthly	<b>Less than 100% Review</b>
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly

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

**Performance Measure:**

**Number and percent of participants whose records documented that a list of waiver services and providers was provided to and discussed with, the waiver participant**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10%
	<b>Other</b> Specify:  _____	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:  <input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of participant records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered among waiver services and providers

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation ( <i>check each that applies</i> ):	Frequency of data collection/generation ( <i>check each that applies</i> ):	Sampling Approach ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/> 10%
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of waiver participant records reviewed with an appropriately completed and signed freedom of choice form that specified choice was offered between institutional care and waiver services

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>

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

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/> 10%
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

The AMA has granted the OA the authority to determine participant service plans. The AMA is available to assist OA in these determinations, if needed. The AMA LTC Division will conduct retrospective record reviews on a monthly basis. The AMA LTC Division also reviews a percentage of case management records on a quarterly basis.

**b. Methods for Remediation/Fixing Individual Problems**

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

The AMA LTC Division will advise the OA of any concerns detected during the monthly record review. The OA is required to submit additional information, and/or develop a corrective action plan. The LTC Division will evaluate the plan of correction for adequacy in addressing the area(s) of concern.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

## Appendix E: Participant Direction of Services

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

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

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

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

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

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

**No.** Independence Plus designation is not requested.

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (6 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (7 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (8 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-1: Overview (9 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-1: Overview (10 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-1: Overview (11 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-1: Overview (12 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-1: Overview (13 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant Direction (1 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (2 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (3 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (4 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

## 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.

AIDS Waiver applicants, participants, or his/her legal representative are informed by case managers of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E at initial application when the individual is offered a choice of waiver services vs institutional services and choice of the provider of service, at annual recertifications and reminded as needed. The aforementioned individuals are notified both verbally and in writing.

In addition applicants, participants, or his/her legal representative are notified by the case manager of their right to request a fair hearing under the following circumstances:

- 1) There is an increase, reduction, suspension or termination in services authorized in the plan of care; or
- 2) Waiver services are not reinstated following a participant's discharge from a nursing home; or
- 3) The participant or DSP requests authorization of a service which is not approved by the Operating Agency.

Whenever a decision is made to reduce, suspend or terminate AIDS waiver services the applicant, participant, or his/her legal representative is notified in writing by the case manager about the decision and informed of their right to request a fair hearing. Denials based on Rule No. 560-X-58-.03, may request a fair hearing in accordance with 42 C.F.R. Section 4331, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code. The Notice of Action form must give the participant specifics regarding the reason for the reduction, suspension or termination. The Notice of Action form is mailed at least 10 days before the action becomes effective. The case manager is available to provide any assistance the participant may need to request a fair hearing in a timely manner. The appeal rights are included in the Notice of Action. The participant's services will continue, upon request, while their appeal is under consideration.

The OA will be responsible for taking a lead role in the fair hearing process by preparing and conducting the fair hearing. Medicaid legal counsel and program staff will function as support staff. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving

their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Alabama does operate 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. The participant, applicant, or his/her legal representative can request an appeal if they disagree with a decision to reduce, suspend, or terminate AIDS Waiver services. To initiate the Informal Conference the participant, applicant, or his/her legal representative must send a written request to the Alabama Department of Senior Services within 30 days from the date of the notice of action. All parties are then notified in writing by ADSS of the date, time, and place of the Informal Conference. In the event the participant, applicant, or his/her legal representative is unable to attend the Informal Conference the individuals are given an opportunity to submit documentary evidence to substantiate their position.

The informal conference provides the individual an opportunity to quickly resolve any adverse actions which the participant, applicant, or his/her legal representative may deem inappropriate. However, individuals requesting an Informal Conference retain the right to request a Fair Hearing if the dispute is not resolved through this process. The participant, applicant, or his/her legal representative must submit a written request for a fair hearing no later than 30 days from the date of the notice of action. (letter notifying recipient of the Informal Conference outcome).

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under the AIDS Waiver. The grievance/complaint system in the AIDS Waiver is managed and maintained by the Operating Agency (OA) for the AIDS Waiver, the Alabama Department of Senior Services.

The OA has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered. The OA will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency. Complaints which are made against a Case Manager will be investigated by the OA and documented. All other complaints will be referred to the Case Manager who will take appropriate action.

The Administering Agency for the AIDS Waiver, the Alabama Medicaid Agency, monitors and tracks resolution of grievances and complaints to ensure they are addressed and resolved. The operating agency submits a complaint and grievance log to the Medicaid Agency for review quarterly.

- 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).

Waiver applicants/participants are informed of procedures necessary to file a formal compliant or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility. Written information is maintained in the participants home about this process as well.

When complaints and grievances arise every attempt is made to resolve them at the local level. When this effort is not successful the grievance process is initiated. Waiver participants are encouraged to advise the case manager of any dissatisfaction relative to any aspect of the care or services received through the AIDS Waiver. Clients may register a complaint or grievance relating to denial, reduction or change in waiver services, financial eligiblity, Direct Service Providers, Direct Service Workers or with the case manager. If the complaint or grievance is lodged against the case manager the operating agency is responsible for resolving the concerns. If the complaint or grievance is lodged against the operating agency the Medicaid Agency is responsible for resolving the concerns.

The case manager must follow-up and facilitate discussion with the participant or his/her legal representative to determine the concern or dissatisfaction which resulted in the complaint or grievance. Following this "fact finding" discussion the case manager must proceed with appropriate interventions. The case manager should continue a dialogue with the participant or or his/her legal representative to ensure the interventions are successful and address the concerns or dissatisfactions. The case manager must document all discussions or actions taken to resolve the compliants or grievances on the Client Complaint/Grievance Report.

The operating agency is required to report quarterly to the Medicaid Agency any complaint or grievance including the nature of the complaint/grievance, disposition, and resolution.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state of Alabama requires that incidences of alleged abuse, neglect or exploitation are reported for review and follow-up action to the Department of Human Resources (DHR) Adult Protective Services Division at the local level in the participant's/applicant's county of residence.

Adult Abuse is defined under Section 38-9-2,Code of Alabama, as "the infliction of physical pain, injury or the willful deprivation by a caregiver or other person of services necessary to maintain mental and physical health". Adult Neglect is defined as "the failure of a caregiver to provide food, shelter, clothing, medical services and health care for the person unable to care for himself; or the failure of the person to provide these basic needs for himself when the failure is the result of the person's mental or physical inability". Exploitation is defined as "the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or his legally authorized representative".

The Adult Protective Services Act of 1976 defines the responsibilities of the Alabama Department of Human Resources, law enforcement authorities, caregivers, individuals, and agencies in reporting and investigating cases of suspected or confirmed abuse, neglect or exploitation of adults who are incapable of protecting themselves and who have no one willing or able to protect them. Instances of suspected abuse, neglect or exploitation must be reported immediately to the Adult Protective Services Unit at the DHR in the participant's/applicant's county of residence, the chief of police or sheriff. An oral report, either by telephone or in person, must be made followed with a written report. Other incidents such as a fall must be reported to the Direct Service Provider Agency and the case manager for follow-up. The Adult Protective Services Division also maintains an Adult Abuse Hotline which is staffed during regular business hours and available twenty-four hours a day, seven days a week.

If the case manager or direct service provider worker become aware of any of the following critical incidents or events the occurrences must be reported within the following time frames established by the state:

Type of Incident	Timeframe for Report	Report To
Physical Abuse	Immediately	DHR/Case Manager
Sexual Abuse	Immediately	DHR/Case Manager
Verbal Abuse	Immediately	DHR/Case Manager
Neglect	Immediately	DHR/Case Manager
Mistreatment	Immediately	DHR/Case Manager
Exploitation	Within 24 hours	DHR/Case Manager
Moderate Injury	Within 24 Hours	DHR/Case Manager
Major Injury	Within 24 Hours	DHR/Case Manager
Death	Immediately	Case Manager
Natural Disaster	Within 24 Hours	Case Manager
Fire	Within 24 Hours	Case Manager
Fall	Within 24 hours	Case Manager

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with consumers to encourage them to talk about what is important to them as well as what they do not like. Each recipient is informed of his/her rights and responsibilities during the initial assessment. The Rights and Responsibilities are given to the recipient and kept in the home file. The legal guardian and/or advocate is informed of the recipient's rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand. The case manager and the DSP is responsible for informing the client/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect/or exploitation.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Alabama Department of Senior Services is the entity that receive reports of critical events or incidents. The Online Document Management (ODM) software will be used to document the incidents, follow-up and the resolution. The operating agency (OA) will investigate the critical events reported and make a decision within seven (7) working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse require an investigation. If the OA determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and arrange when appropriate. Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants through individual/family interviews. The OA will notify Medicaid's HIV/AIDS Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken. In addition, Medicaid's LTC Division is responsible for overseeing the reporting of and response to critical incidents through a review of quarterly participation satisfaction surveys, a review of complaint logs, medical record reviews, DSP personnel record reviews, and onsite home and provider visits, when deemed necessary.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

#### The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The unauthorized use of restraints or seclusion is not applicable as services in this waiver are provided in the community in participant's home or place of residence.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** (*Select one*):

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The unauthorized use of restrictive interventions is not applicable as services in this waiver are provided in the community in participant's home or place of residence.

**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.

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**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:

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## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** (*Select one*): (*This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.*)

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

--

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**i. Provider Administration of Medications.** *Select one:*

**Not applicable.** (*do not complete the remaining items*)

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (*complete the remaining items*)

**ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

##### i. Sub-Assurances:

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

#### Performance Measures

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

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

#### Performance Measure:

**Number and percent of satisfaction survey respondents who reported they are not treated with respect and dignity**

#### Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

Specify:  [Redacted]		Describe Group:  [Redacted]
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  [Redacted]
	<b>Other</b> Specify:  [Redacted]	

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  [Redacted]
Other Specify:  [Redacted]	Annually	Stratified Describe Group:  [Redacted]
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10% [Redacted]

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of critical incident review/investigations that were initiated within required time frames as specified in the approved waiver**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of critical incident reviews/investigations that were completed within required time frames as specified in the approved waiver

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

		Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of substantiated complaints****Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid	Weekly	100% Review

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of experience/satisfaction survey respondents who reported someone hit or hurt them physically**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  _____
Other Specify:  _____	Annually	Stratified Describe Group:  _____
	Continuously and Ongoing	Other Specify:  10% _____
	Other Specify:  _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
Other Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified in the approved waiver**

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:****Number and percent of complaints addressed within required time frame****Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

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

	Specify:  <input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of satisfaction survey respondents who reported that the workers were not doing a good job.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other Specify:</b> 10%
	<b>Other Specify:</b>  [Redacted]	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  [Redacted]	Annually
	Continuously and Ongoing
	Other Specify:  [Redacted]

**Performance Measure:**

Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

		Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of participants reviewed who received the coordination and support to access health care services identified in their service plan**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of satisfaction survey respondents who reported they do not feel safe when they live**

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	<b>Other</b> Specify:	

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**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
State Medicaid Agency	Weekly	<b>100% Review</b>
Operating Agency	Monthly	<b>Less than 100% Review</b>
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly

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

**Performance Measure:**

**Number and percent of experience/satisfaction survey respondents who reported that people take their things without asking**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  10%
	<b>Other</b> Specify:  _____	

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:  _____	
--	-----------------------	--

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  _____	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  _____

**Performance Measure:**

Number and percent of participants (and/or legal guardians) reporting they received information/education in the prior year about how to report abuse, neglect, exploitation, and other critical incidents as determined by the state

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation ( <i>check each that applies</i> ):	Frequency of data collection/generation ( <i>check each that applies</i> ):	Sampling Approach ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other Specify:</b> 10%
	<b>Other Specify:</b>  [Redacted]	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  [Redacted]	Annually
	Continuously and Ongoing
	Other Specify:  [Redacted]

**Performance Measure:**

Number and percent of critical incidents that were reported within the required time frames as specified in the waiver

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

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

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

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

		Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of participant records reviewed where the participant (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/> 10%
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

#### Performance Measures

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

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

- c. Sub-assurance:** *The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

#### Performance Measures

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

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

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

#### Performance Measures

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

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

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

The Case Manager will monitor participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager will also report any events of this nature to the waiver administrator in the approved format who will forward to AMA within the required guidelines. The Case Manager will track reports to resolution for documentation and will report the resolution to the waiver administrator to forward to AMA.

**b. Methods for Remediation/Fixing Individual Problems**

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

AMA conducts participant satisfaction surveys on a quarterly basis. The results of the surveys are relayed to the Operating Agency (OA). The OA is responsible for keeping a log of complaints/grievances that must be tracked through to resolution on an on-going basis. This log is to be sent to AMA on a quarterly basis. Grievances are to be resolved in an appropriate and timely manner, or the OA will be asked to submit a Plan of Correction to ensure prevention of re-occurrence. The OA will be notified of any complaints/grievances received by AMA involving the OA or any of its providers of care. The OA performs periodic telephone interviews with waiver participants statewide to ensure services are provided appropriately and to ensure that the participant is satisfied with services received.

The AMA sends a satisfaction survey to 10% of those receiving waiver services during the year. The sample is selected randomly. The HIV/AIDS Waiver Nurse will discuss the responses of dissatisfaction with the waiver Case Manager who provides follow-up with the client and reports findings and resolution to the AMA. For the provision of Assistive Technology, Environmental Accessibility Adaptations, and Minor Assistive Technology services, the participant signs a form prior to vendor payment to ensure satisfaction of service.

The results of the satisfaction surveys are kept on file and any comment or dissatisfaction is followed up on by the waiver Case Manager through resolution. Each waiver participant, at initial application and each year at the time of the re-evaluation of services will be provided a copy of the Complaint/Grievance Policy and Procedure Form that provides them with directions on how to complain to the Case Manager and to the HIV/AIDS Coordinator or their designee. The Case Manager will follow-up with all complaints through resolution.

The AMA Review Coordinator will review a random sample of 10% case management and direct service provider records for recipients of the HIV/AIDS Waiver, annually to ensure compliance with the waiver documents and participant satisfaction with services provided. Home visits are not routinely completed at this time. Home visits are completed when there is a health and safety concerns that cannot be resolved at the local level.

**ii. Remediation Data Aggregation**

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

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 50px; width: 100%;"></div>

### c. Timelines

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

**No**

**Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; 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 OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

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### **H-1: Systems Improvement**

#### **a. System Improvements**

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

**Description of the Quality Management Program for the HIV/AIDS Waiver**

The Quality Management Strategy for the HIV/AIDS Waiver is:

AMA LTC Division is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the HIV/AIDS Waiver program. The Quality Framework is used as a guide to assess seven Program Design Focus areas from samples of waiver participants, case management and direct service providers records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. AMA LTC Division will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are to be made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

**Participant Access**

Sources of data:

- Case Management Records
- Home Visits
- DSS Queries
- Consumer Surveys

**ParticipantCentered Service Planning and Delivery**

Sources of data:

- Consumer Surveys
- Case Management Records
- Site Visits
- Home Visits

**Provider Capacity and Capabilities**

Sources of data:

- Consumer Surveys
- Case Management Records
- Personnel and Training Records of Operating Agency and Subcontractors
- Home Visits

**Participants Safeguards**

Sources of data:

Case Management Records

Consumer Surveys

Home Visits

Site Visits

#### Participants Rights and Responsibilities

Sources of data:

Consumer Surveys

Case Management Records

Complaint and Grievances Logs

Targeted Surveys

#### Patient Satisfaction

Sources of data:

Consumer Surveys

Case Management Records

Home Visits

Site Visits

#### System Performance

Sources of data:

Review of Operating Agency Quality Assurance System

Review of Operating Agency Billing and Service Provision

Collaborative Meeting with Operating Agency to enhance the administration of the Program

Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaids Long Term Care Division:

Percentage of participant/family reporting satisfaction with waiver services and needs met.

Percentage of participant/family reporting they feel safe and secure in the home and community.

Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.

Percentage of participant/family reporting knowledge of rights and responsibilities.

Percentage of records indicating services are planned and implemented according to the participants needs and preferences.

Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.

Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing

Medicaid will, through its monitoring process, discover problems, and resolve them. Any area of concern which may need to be addressed is reported to the Director of the Long Term Care Division. The Director of the Long Term Care Division will contact the Operating Agency to share the results of the audit. The findings may be addressed through training regarding policies and regulations to changes in the MMIS edits and audits.

The Administration of the Operating Agency will jointly consider the findings from case management records and field visits and determine the necessary actions. This information is shared during the Quarterly Operating Agency meeting. Recommendations for changes will be done at this meeting. Implementation which require changes in the rule must be approved by the Department of Senior Services. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Prioritized recommendations will be reviewed by the Director of Long Term Care. Some recommendations require the approval of the Associate Commissioner. These changes will be implemented with the support of the Operating Agency.

Recently, a software tool called Online Document Management (ODM) was designed to manage the complaint and grievance system. The ODM software is utilized to document the complaints and grievances. The tool allows the case managers, ADSS, and AMA to track the ongoing efforts to resolve the issue. The tool also produces reports that can be used for quality assurance purposes.

The timelines established by Alabama Medicaid Agency (AMA) for review and action regarding the complaints and grievances are incorporated into the software. The software produces alerts based on the required timelines to ensure issues are addressed in the scheduled manner specified by AMA.

When complaints are received, a form is completed in ODM within two working days. The ODM administrator receives notification of the form and the process of review and remediation begins. All complaints are investigated upon receipt of notification. Appropriate parties must initiate follow-up within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed.

This system allows the Administering Agency for the HIV/AIDS Waiver and the AMA to closely monitor and track the resolution of grievances and complaints, in a timely manner, to ensure they are addressed and resolved.

The Alabama Medicaid Agency will contact the National Quality Enterprise to seek technical assistance regarding the development of quality improvement strategies.

## ii. System Improvement Activities

<b>Responsible Party</b> (check each that applies):	<b>Frequency of Monitoring and Analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Other</b> Specify:  <input type="text"/>

## b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Medicaid Agency LTC Division is responsible for collecting data regarding the quality of services provided from various sources for the HIV/AIDS Waiver. Data is collected using quality indicators from each of the seven Program Design Focus areas of the Quality Framework as a guide. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions.

The ODM software system is monitored closely by the Administering Agency (OA) for the HIV/AIDS Waiver as well as the AMA. The timelines designed into the systems allows both agencies to determine if issues were addressed in a timely manner. The AMA will contact the recipient and/or responsible party and the case manager via telephone to ensure full complaint resolution has been reached within the specified timeframes.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Alabama Medicaid Agency will revisit the methodology for determining a statistically valid sample size by using the sample size calculator to determine the sample size with a 95% confidence level and a 5% margin of error. All performance measures will be changed to reflect a statistically valid sample size.

Collected data is reported quarterly and annually to the Operating Agency and to Medicaid's LTC Division for evaluation and recommendations for program improvements. The LTC Division of the Medicaid Agency is the administering authority over the HIV/AIDS Waiver Program; therefore, recommendations for improvements will be evaluated by the LTC Division for final determination of changes to the program.

Meetings are held periodically to determine if the system is continuing to provide the desired results. At some point, funding maybe a system, otherwise, the system has proven to be a value tool for monitoring and tracking the resolution of grievances and complaints.

## Appendix H: Quality Improvement Strategy (3 of 3)

### 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

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:**

**HCBS CAHPS Survey :**

**NCI Survey :**

**NCI AD Survey :**

**Other** (*Please provide a description of the survey tool used*):

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

*The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:*

*The Alabama Medicaid Agency serves as the administering agency for the HIV/AIDS Waiver. The operating agency is the Alabama Department of Senior Services. The Medicaid Agency is audited, externally by the Alabama Department of Public Examiners of Public Accounts.*

*The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews and targeted reviews of claims are performed when potential system errors are identified. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, service limitations and related services are compared to Medicaid policy and guidelines.*

*Monthly reports of expenditures are received by the waiver coordinator 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.*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

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

**a. Methods for Discovery: Financial Accountability Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

*(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

#### **Performance Measures**

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

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

**Performance Measure:**

*Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered*

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

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

***Data Aggregation and Analysis:***

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

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

***Performance Measure:***

***Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application***

***Data Source (Select one):***

***Record reviews, on-site***

*If 'Other' is selected, specify:*

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

***Data Source (Select one):***

***Record reviews, off-site***

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <input type="text"/>
<i>Other Specify:</i>  <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>  <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i>  <input type="text"/> 10%
	<i>Other</i> <i>Specify:</i>  <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's service plan**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<i>Other</i> Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	<i>Continuously and Ongoing</i>	<i>Other</i> Specify:  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
	<i>Other</i> Specify:	

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***Data Source (Select one):******Record reviews, off-site******If 'Other' is selected, specify:***

<b><i>Responsible Party for data collection/generation (check each that applies):</i></b>	<b><i>Frequency of data collection/generation (check each that applies):</i></b>	<b><i>Sampling Approach (check each that applies):</i></b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <input type="text"/>
<i>Other Specify:</i>  <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>  <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i>  <input type="text"/> 10%
	<i>Other</i> <i>Specify:</i>  <input type="text"/>	

***Data Aggregation and Analysis:***

<b><i>Responsible Party for data aggregation and analysis (check each that applies):</i></b>	<b><i>Frequency of data aggregation and analysis (check each that applies):</i></b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>  [Redacted]	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i>  [Redacted]

- b. Sub-assurance:** *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

#### **Performance Measures**

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

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

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

*The AMA has contracted with a fiscal agent to maintain the payment records on services received and billed under the HIV/AIDS Waiver. The OA ensures that all services and corresponding payments are coded and documented properly. The OA ensures that only those services included on the plan of care are billed for the HIV/AIDS Waiver participant.*

*The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and HIV/AIDS Waiver eligibility before the claims are paid. The AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.*

*To ensure maximum reimbursement to services providers, the AMA is notified of any claims payment issues and will work with the OA and the fiscal intermediary to resolved the issues.*

*The AMA through the Decision Support System can generate adhoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.*

**b. Methods for Remediation/Fixing Individual Problems**

- i.** *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on*

*the methods used by the state to document these items.*

*AMA has a Program Administrator within the Long Term Care Division that provides assistance to the OA to address individual problems as they are identified. All issues will be coordinated with the appropriate entity: Medicaid Eligibility Division, Fiscal Agent Liaison, etc., for resolution. If the issue cannot be resolved on that level, the issue will be reported to the Long Term Care Division Director for further intervention.*

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Alabama Medicaid Agency is responsible for establishing provider payment rates for AIDS Waiver services. Payments made by Medicaid to AIDS Waiver providers are on a fee-for-service basis and are based upon the following factors:

- Current pricing for similar services
- State-to-State comparisons
- Geographical comparisons within the state
- Comparisons of different payers for similar services

A procedure code is determined for each waiver service and a rate is assigned to each code. The Medicaid Management Information System (MMIS) pays the claim based upon the States determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Rates established are reasonable and customary to ensure continuity of care, quality of care and continued access to care. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index.

Rate changes are submitted to the Medicaid Advisory Committee for review. The Chairman of the Medicaid Advisory Committee is the Alabama Medicaid Agency Commissioner. Once the rate change is submitted to the Medicaid Advisory Committee for discussion, the Commissioner will discuss the impact of the change and make a recommendation.

**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 Agency's Long Term Care (LTC) File. This file holds approved dates of eligibility for waiver services.

Provider billing flows directly from the providers to the States claim payment system (MMIS) through Hewlett-Packard(HP), 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 HCPC code.

For each recipient, the claim allows span billing for a period not to exceed one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. Each service type is identified by a procedure code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.

If the submitted claim covers dates of services where a part or all of the services were covered in a previously paid claim, then the entire claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.

Payment is based on the number of units of service reported on the claim for each procedure code.

Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.

. All claims must be filed within twelve months from the date of service. Medicaid recovers payments that exceed actual allowable cost.

. Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures (select one):**

**No. state or local government agencies do not certify expenditures for waiver services.**

**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services**

*and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.*

*Select at least one:*

***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

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## ***Appendix I: Financial Accountability***

### ***I-2: Rates, Billing and Claims (3 of 3)***

***d. Billing Validation Process.*** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The System performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edits ensure the recipients 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 times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by HP personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published in the Provider Insider, the Alabama Medicaid provider bulletin produced by HP. The check is sent to the providers payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the providers bank account and the EOP is mailed separately to the provider.

The case manager has the responsibility of checking the billing against the time sheets regardless of the decision of the direct service provider to contract directly with Medicaid or with the AAAs. The case manager also inquires during the face-to-face home visit regarding service delivery.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## **Appendix I: Financial Accountability**

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### **I-3: Payment (1 of 7)**

**a. Method of payments -- MMIS (select one):**

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

--

*Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.*

*Describe how payments are made to the managed care entity or entities:*

--

## **Appendix I: Financial Accountability**

### **I-3: Payment (2 of 7)**

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

--

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

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## **Appendix I: Financial Accountability**

### **I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the

*supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

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## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The State of Alabama Department of Senior Services is the operating agency for the HIV/AIDS Waiver. The services provided are Skilled Nursing, Skilled and Unskilled Respite, Personal Care and Companion Services, Homemaker and Case Management.

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## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

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## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

**No.** The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

**Yes.** Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

Direct Service Providers may reassign payments only to ADSS, the operating agency for the AIDS 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.

**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 Area Agencies on Aging (AAA) provides one or more waiver service and are therefore eligible to be an OHCDS. Providers may enroll directly with Medicaid if they choose to do so. Free choice of providers is assured by the policies and procedures in effect and practices carried out by the case managers. All qualified and available providers are enrolled and monitored by Quality Assurance reviews performed by ADSS or Medicaid to ensure that they meet the provider qualifications in the waiver document. All subcontractors are submitted to the state for review of applicable provisions.*

*The OA performs all preliminary functions (waiver & provider requirements, scopes of services, policies & procedures etc). If the potential provider meets the requirements but does not want to contract with the OA, the OA will forward the information to Medicaid's Waiver Program Manager to enroll directly with the Agency. The Medicaid Program Manager will notify the provider of the process and direct them on how to apply for an NPI number. Once the provider has the NPI number, they may complete the enrollment application on www.medicaid.alabama.gov.*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

***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.***

***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

***In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.***

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## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

Check each that applies:

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

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## Appendix I: Financial Accountability

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### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** Select one:

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

**Do not complete this item.**

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## Appendix I: Financial Accountability

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### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** Select one:

**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when**

*the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

**No. The state does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

Specify:

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

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*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

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## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

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*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

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## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	7938.39	11359.00	19297.39	38395.00	2021.00	40416.00	21118.61
2	8243.30	11700.00	19943.30	39547.00	2082.00	41629.00	21685.70
3	8678.59	12051.00	20729.59	40733.00	2144.00	42877.00	22147.41
4	9134.67	12412.00	21546.67	41955.00	2208.00	44163.00	22616.33
5	9609.21	12784.00	22393.21	43214.00	2274.00	45488.00	23094.79

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who

will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

*Table: J-2-a: Unduplicated Participants*

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	150		150
Year 2	150		150
Year 3	150		150
Year 4	150		150
Year 5	150		150

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay is derived by dividing the total number of participant days in a waiver year by the total number of participants served. This information is based on data in the CMS-372 report for the applicable years.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is derived from data shown on the CMS - 372 Report with a 3.0 percent inflation factor applied to each year of the renewal period.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D is derived from data shown on the CMS - 372 Report with a 3.0 percent inflation factor applied to each year of the renewal period.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from data shown on the CMS - 372 Report with a 3.0 percent inflation factor applied to each year of the renewal period.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from data shown on the CMS - 372 Report with a 3.0 percent inflation factor applied to each year of the renewal period.

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Case Management	
Homemaker	
Personal Care	
Respite	
Companion Services	
Skilled Nursing	

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

**i. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Case Management Total:</b>						<b>441983.52</b>
Case Management	15 minutes	144	131.00	23.43	441983.52	
<b>Homemaker Total:</b>						<b>240489.60</b>
Homemaker	15 minutes	123	416.00	4.70	240489.60	
<b>Personal Care Total:</b>						<b>445588.00</b>
Personal Care	15 minutes	50	1976.00	4.51	445588.00	
<b>Respite Total:</b>						<b>34957.20</b>
Unskilled Respite	15 minutes	25	300.00	4.36	32700.00	
Skilled Respite	15 minutes	15	24.00	6.27	2257.20	
<b>Companion Services Total:</b>						<b>8442.00</b>
Companion Services	15 minutes	20	126.00	3.35	8442.00	
<b>GRAND TOTAL:</b>						<b>1190757.92</b>
Total Estimated Unduplicated Participants:						<b>150</b>
Factor D (Divide total by number of participants):						<b>7938.39</b>
Average Length of Stay on the Waiver:						<b>273</b>

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Skilled Nursing Total:</b>						<b>19297.60</b>
Skilled Nursing	1 hour	10	56.00	34.46	19297.60	
<b>GRAND TOTAL:</b>						
					1190757.92	
					150	
					7938.39	
					273	
<i>Average Length of Stay on the Waiver:</i>						

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. 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 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Case Management Total:</b>						<b>455188.32</b>
Case Management	15 minutes	144	131.00	24.13	455188.32	
<b>GRAND TOTAL:</b>						
					1236494.52	
					150	
					8243.30	
					273	
<i>Average Length of Stay on the Waiver:</i>						

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (7 of 9)****d. Estimate of Factor D.**

**i. 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 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Case Management Total:</b>						<b>475281.10</b>
Case Management	15 minutes	146	131.00	24.85	475281.10	
<b>Homemaker Total:</b>						<b>263103.36</b>
Homemaker	15 minutes	127	416.00	4.98	263103.36	
<b>Personal Care Total:</b>						<b>490127.04</b>
Personal Care	15 minutes	52	1976.00	4.77	490127.04	
<b>Respite Total:</b>						<b>37837.20</b>
Unskilled Respite	15 minutes	25	300.00	4.62	34650.00	
Skilled Respite	15 minutes	20	24.00	6.64	3187.20	
<b>Companion Services Total:</b>						<b>8946.00</b>
Companion Services	15 minutes	20	126.00	3.55	8946.00	
<b>Skilled Nursing Total:</b>						<b>26493.60</b>
Skilled Nursing	1 hour	15	56.00	31.54	26493.60	
<b>GRAND TOTAL:</b>						<b>1301788.30</b>
Total Estimated Unduplicated Participants:						<b>150</b>
Factor D (Divide total by number of participants):						<b>8678.59</b>
Average Length of Stay on the Waiver:						<b>273</b>

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

**i. 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 4**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Case Management Total:</b>						<b>496138.92</b>
Case Management	15 minutes	148	131.00	25.59	496138.92	
<b>Homemaker Total:</b>						<b>274759.68</b>
Homemaker	15 minutes	129	416.00	5.12	274759.68	
<b>Personal Care Total:</b>						<b>523916.64</b>
Personal Care	15 minutes	54	1976.00	4.91	523916.64	
<b>Respite Total:</b>						<b>38903.40</b>
Unskilled Respite	15 minutes	25	300.00	4.75	35625.00	
Skilled Respite	15 minutes	20	24.00	6.83	3278.40	
<b>Companion Services Total:</b>						<b>9198.00</b>
Companion Services	15 minutes	20	126.00	3.65	9198.00	
<b>Skilled Nursing Total:</b>						<b>27283.20</b>
Skilled Nursing	1 hour	15	56.00	32.48	27283.20	
<b>GRAND TOTAL:</b>						<b>1370199.84</b>
Total Estimated Unduplicated Participants:						<b>150</b>
Factor D (Divide total by number of participants):						<b>9134.67</b>
Average Length of Stay on the Waiver:						<b>273</b>

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**i. 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 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Case Management Total:</b>						<b>517777.50</b>
Case Management	15 minutes	150	131.00	26.35	517777.50	
<b>Homemaker Total:</b>						<b>287193.92</b>
<b>GRAND TOTAL:</b>						<b>1441381.62</b>
Total Estimated Unduplicated Participants:						<b>150</b>
Factor D (Divide total by number of participants):						<b>9609.21</b>
Average Length of Stay on the Waiver:						<b>273</b>

<i>Waiver Service/ Component</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
<i>Homemaker</i>	<i>15 minutes</i>	<i>131</i>	<i>416.00</i>	<i>5.27</i>	<i>287193.92</i>	
<i>Personal Care Total:</i>						<i>558812.80</i>
<i>Personal Care</i>	<i>15 minutes</i>	<i>56</i>	<i>1976.00</i>	<i>5.05</i>	<i>558812.80</i>	
<i>Respite Total:</i>						<i>40049.40</i>
<i>Unskilled Respite</i>	<i>15 minutes</i>	<i>25</i>	<i>300.00</i>	<i>4.89</i>	<i>36675.00</i>	
<i>Skilled Respite</i>	<i>15 minutes</i>	<i>20</i>	<i>24.00</i>	<i>7.03</i>	<i>3374.40</i>	
<i>Companion Services Total:</i>						<i>9450.00</i>
<i>Companion Services</i>	<i>15 minutes</i>	<i>20</i>	<i>126.00</i>	<i>3.75</i>	<i>9450.00</i>	
<i>Skilled Nursing Total:</i>						<i>28098.00</i>
<i>Skilled Nursing</i>	<i>1 hour</i>	<i>15</i>	<i>56.00</i>	<i>33.45</i>	<i>28098.00</i>	
<b>GRAND TOTAL:</b>						<b>1441381.62</b>
<i>Total Estimated Unduplicated Participants:</i>						<i>150</i>
<i>Factor D (Divide total by number of participants):</i>						<i>9609.21</i>
<i>Average Length of Stay on the Waiver:</i>						<b>273</b>