ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-35
HOME- AND COMMUNITY-BASED WAIVER FOR PERSONS WITH INTELLECTUAL DISABILITIES

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560-X-35-.01 Authority And Purpose.

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

(2) The HCBS covered in the ID Waiver are Residential Habilitation Services, Supported Living Services, Day Habilitation Services, Prevocational Services, Supported Employment Services,

Occupational Therapy Services, Speech and Language Therapy Services, Physical Therapy Services, Positive Behavior Support Services, Adult Companion Services, Respite Care Services, Personal Care Services, Environmental Accessibility Adaptations Services, Specialized Medical Supplies Services, Skilled Nursing Services, Assisted Technology Services, Crisis Intervention Services, Benefits and Career Counseling Services, Community Experience Services, Housing Stabilization Services, Individual Directed Goods and Services, Supported Employment Transportation Services, Personal Emergency Response System Services, and Remote Support Services. These HCBS provide assistance necessary to ensure optimal functioning of individuals with intellectual disabilities.

(3) The ID Waiver is administered with a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health. The HCBS under the ID Waiver are limited to individuals with a diagnosis of an intellectual disability, age 3 and above.

(4) Home and Community-Based Services for the ID Waiver are provided in compliance with the provisions of the HCBS Settings Final Rule (CMS 2249-F/2296-F). These provisions require the following:

(a) Services may only be provided in settings that:

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

2. Are selected by the individual from among setting options;

3. Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;

4. Optimize autonomy and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact;

5. Facilitate choice regarding services and who provides them.

(b) A compliant provider-owned or controlled residential setting will also be physically accessible to the individual, and, in addition to the above requirements, meet all of the following requirements:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

2. Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Individuals sharing units have a choice of roommates in that setting. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. Individuals are able to have visitors of their choosing at any time.

3. Modifications to any of the additional requirements for provider owned or controlled residential setting listed above must be:

(i) Supported by specific assessed need

(ii) Justified in the person-centered service plan

(iii) Documented in the person-centered service plan, which must include:

(I) Specific individualized assessed need

(II) Prior interventions and supports including less intrusive methods

(III) Description of condition proportionate to assessed need

(IV) Ongoing data measure effectiveness of modification

(V) Established time limits for periodic review of modifications

(VI) Individual informed consent

(VII) Assurance that interventions and supports will not cause harm.

(c) Services may not be provided in:

1. Excluded settings that include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals.

2. Presumed institutional settings that include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

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560-X-35-.02 Description Of Services.

Home and Community-Based Services (HCBS) under the Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver) are defined as Title XIX Medicaid-funded services

provided to individuals with intellectual disabilities who, without these services, would require services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID). These HCBS under the ID Waiver will provide health, social, and related support needed to ensure optimal functioning of individuals with intellectual disabilities within a community setting. The Administering Agency may provide or subcontract for any HCBS under the ID Waiver. To qualify for Medicaid reimbursement, each individual HCBS must be necessary to prevent institutionalization of the waiver recipient. Each provider of HCBS must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as HCBS under the ID Waiver. The following are specific HCBS available under the ID Waiver:

(1) Residential Habilitation Services

(a) Residential Habilitation shall mean a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident’s independence and full integration into the community, and ensures each resident’s choice and rights.

(b) Residential Habilitation Services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation Provider, and shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, and set forth in the person-centered plan.

(c) Residential Habilitation Services provide care, supervision, and skills training in activities of daily living, home management and community integration.

(d) A fraction of this service may be delivered remotely via remote supports/monitoring if:

1. appropriate for the participant as determined by the PCP team;

2. all requirements for this service as outlined in this service definition are met; and

3. all requirements in Appendix C-1-d are met. In these situations, the provider of this service is expected to contract with a remote support/remote monitoring provider that is paid for its technology and services by the service provider. On a case-by-case

basis, ADMH staff will evaluate the provider's use of remote support/remote monitoring with a participant(s) to determine the impact on the provider's cost to deliver the service and determine if a rate adjustment is needed.

(e) Residential Habilitation services include training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities.

(f) Residential Habilitation services will be delivered/ supervised by a Qualified Developmental Disabilities Professional (QDDP) in coordination with the waiver's recipient's approved person-centered care plan.

(g) Residential Habilitation services include the provision of medical and health care services that are integral to meeting the daily needs of residents, but do not include medical and health care services that are not routinely provided to meet the daily needs of residents.

(h) Providers of Residential Habilitation must be certified by the Alabama Department of Mental Health. No new home will be certified for residence of more than six individuals.

(i) Residential Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

(j) Residential Habilitation excludes the following:

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

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

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

4. Room and board costs.

(k) Transportation costs to transport individuals to day programs, social events or community activities when public transportation and/or transportation covered under the Medicaid state plan are not available will be included in payments made to providers of residential habilitation. In-Home Habilitation service workers may

transport consumers in their own vehicles as an incidental component of this service.

(2) Supported Living Services

(a) Supported Living Services shall mean services that include training and assistance in maintaining a home of one's own, or a home shared with other freely chosen housemates, in the community. A home of one's own means a residence not owned or controlled by any waiver service provider. Supported Living Services supports include supports for maintaining home tenancy or ownership, managing money, preparing meals, shopping, maintaining positive relationships with neighbors, opportunities for participation in and contribution to the local community, supports to maintain personal appearance and hygiene, supports for interpersonal and social skills building through experience with family, friends and members of the broader community, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community. The service shall support and maximize the person's independence through use of teaching, training, technology and facilitation of natural supports.

(b) The service shall support the individual's full integration into the community, ensure the person's choice and rights, and comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including the provision of opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. Further, supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

(c) Supported Living Services also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Alabama's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

(d) Supported Living Services are appropriate for people who need intermittent staff support to remain in their own home and do not require 24/7 staffing.

(e) Individuals receiving Supported Living Services may choose to receive services in a shared living arrangement. Other persons in the shared living arrangement may need differing levels of support,

differing types of waiver services, or may participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely and appropriately meet the needs of each individual in the home. No more than 3 persons receiving services will be permitted per residence.

(f) Reimbursement for Supported Living Services shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent, mortgage, home/renter's insurance, etc.) shall be paid by the person(s) supported and other residents in the home (if applicable), through mutual agreement reached by the persons sharing the dwelling.

(g) A fraction of this service may be delivered remotely via remote supports/monitoring if:

1. appropriate for the participant as determined by the PCP team;

2. all requirements for this service as outlined in this service definition are met; and

3. all requirements in Appendix C-1-d are met. In these situations, the provider of this service is expected to contract with a remote support/remote monitoring provider that is paid for its technology and services by the service provider. On a case-by-case basis, ADMH staff will evaluate the provider's use of remote support/remote monitoring with a participant(s) to determine the impact on the provider's cost to deliver the service and determine if a rate adjustment is needed.

(3) Day Habilitation Services

(a) Day Habilitation Services are services which involve the provision of regularly scheduled activities in non-residential settings, separate from the member's residence or other residential living arrangement. This service can be provided in a Day Habilitation Facility or in the Community. Activities focus on assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social integration and outcomes. Activities are designed to foster the acquisition of positive social skills and interpersonal competence, greater independence and ability to exercise and communicate personal choices and preferences. Day Habilitation Services also provide assistance that supports community participation including achievement of valued social roles that reflect a member's individualized interests and desires with

regard to type(s) of community involvement and community contributions the member prefers.

(b) Day Habilitation Services focus on enabling the member to attain and maintain his or her maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and support plan, such as physical, occupational, or speech therapy. Day Habilitation Services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and competitive integrated employment (or services designed to lead to competitive integrated employment).

(c) Day Habilitation Services are expected to be furnished in a variety of settings in the community, except for the member's residence, that may utilize a provider-owned or controlled setting as a hub or base. Day Habilitation settings must comply fully with the HCBS Settings Rule, therefore ensuring each member's Day Habilitation service plan includes opportunities to participate in a variety of community-based activities that are consistent with the purpose and intended outcome of the service and that facilitate the member's interactions with people from the broader community.

(d) The provider for Day Habilitation Services can be reimbursed based on four levels of Day/Community Habilitation and four levels of Day/Community Habilitation Transportation. Reimbursement rates are associated with each level, based on the associated minimum staffing ratios needed to support persons with different ICAP scores and whether the service is delivered in a facility-based (provider controlled) setting or an integrated community setting, taking account of the more intensive staffing ratios and different costs that are applicable for services delivered in integrated community settings.

(e) Day Habilitation Services cannot exceed five hours per day. Day Habilitation Services may not be used to provide activities involving paid work, including any situation where work done by a member is required to be paid under state and federal labor laws.

(f) Transportation between the Day Habilitation facility and one or more integrated community sites for integrated service delivery time is always included in the service and accounted for in the rate for the service. Transportation between the member's place of residence and the Day Habilitation facility, or site where the member starts and ends Day Habilitation Services each

day, shall either be, included as a component part of Day Habilitation or arranged for the member in another way. If this transportation is provided by the Day Habilitation provider, the cost of this transportation shall be included and accounted for in the rate paid to the provider. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

(4) Prevocational Services

(a) Prevocational services are designed to create a path to competitive integrated employment, which includes competitive integrated self-employment and customized employment or customized self-employment that otherwise meets the criteria for being competitive and integrated. Competitive integrated employment is employment that meets all of the following criteria:

1. Ensures compensation is at least the locally established minimum wage where the member works.

2. Occurs in a location typically found in the community.

3. Enables the member to interact with co-workers and customers to the same extent as a person without a disability filling a similar position.

4. For wage employment, ensures the employer of record is the business or organization benefitting from the work done by the member.

5. Offers the member an individualized position.

(b) Prevocational services involve the provision of learning and skill-building experiences, including community-based volunteering for an organization other than the service provider, where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in competitive integrated employment. Services are intended to develop and teach general skills for competitive integrated employment, including but not limited to: ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training.

(c) Prevocational services are expected to be furnished in a variety of settings in the community, except for the member’s residence or other waiver-funded residential

settings. While a provider may utilize a provider-owned or controlled setting as a hub or base for service delivery, and that setting may include individuals without disabilities who are not receiving HCBS, prevocational services must be delivered consistent with all of the requirements of the HCBS Setting Rule, therefore ensuring each individual's Prevocational service plan includes opportunities to participate in a variety of community-based activities that are consistent with the purpose and intended outcome of the service and that facilitate the individual's access to the broader community and interactions, in the broader community, with people not receiving HCBS.

(d) Reimbursement rates are associated with the minimum staffing ratios needed to support persons based on whether the service is delivered in a facility-based) provider controlled) setting or an integrated community setting, taking into account of the different staffing ratios and different costs that are applicable for services delivered in integrated community settings.

(e) Transportation between the individual's place of residence and the provider facility, or site where the individual starts and ends Prevocational services each day, is included as a component part of the service or arranged for the individual in another way. Transportation during the service is always a component part of the service.

(f) Prevocational services are not otherwise available to the member, in a timeframe that is otherwise typical, through a program funded by ADRS under the section 110 of the Rehabilitation Act of 1973 or, for individuals ages 18-22, through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

(5) Supported Employment Services

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

1. Individual Assessment/Discovery is a one-time, time-1imited, targeted service designed to help a waiver recipient who wishes to pursue individualized, integrated employment or self-employment. Discovery may involve a comprehensive analysis of the waiver recipient's history; interviews with family, friends and support staff; observing the waiver recipient performing work skills; and career research in order to determine the waiver recipient's career interests,

talents, skills, support needs and choice; and the writing of a Profile, which may be paid for through waiver funds in order to provide a valid assessment for Vocational Rehabilitation (VR) services, which will begin with the development of an employment plan through VR.

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

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

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

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

(b) Supported Employment Services are conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

(c) Supported Employment Services also include activities needed to sustain paid employment by waiver recipients, including supervision and training.

(d) When Supported Employment Services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision and training required by waiver recipients as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business settings.

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

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

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

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

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

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

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

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

(6) Occupational Therapy Services.

(a) Occupational Therapy Services include the evaluation of a waiver recipient to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating waiver recipients in the prescribed therapy to secure and/or obtain necessary function.

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

(c) Occupational Therapy requires a physician's prescription and documentation in the form of an initial assessment and development of a treatment plan with established goals that must be present in the case record and must justify the need for service. Services must be listed on the person-centered care plan and be provided and billed in 15-minute units of service. Occupational therapy is limited to no more than 50 hours or 200 units for the initial plan.

(d) Occupational Therapy Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered. Occupational therapists must document each therapy session in a treatment note and must sign each note denoting whether or not progress is made. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the treatment plan.

(7) Speech and Language Therapy Services

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

(b) These services may include:

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

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

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

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

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

(c) Speech and Language Therapy Services must be listed on the care plan and prescribed by the participant's physician and related to a participant's particular diagnosis. An evaluation is required by the speech therapist to determine the need for service. The need of service must be documented in the case record. Services shall be provided and billed as an encounter unit of service. Documentation of service provided by the speech therapist is required for each encounter and each note must be signed by the therapist. Notes must be maintained in the client file. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the treatment plan.

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

(e) Speech and Language Therapy Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(f) Providers of service must maintain a service log that documents specific days on which Speech and Language Therapy Services were delivered.

(8) Physical Therapy Services

(a) Physical Therapy Services include assisting in the determination of a waiver recipient's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

1. Physical Therapy Services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

2. Physical Therapy Services also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

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

(c) Physical Therapy Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(d) Physical Therapy requires a physician's prescription and documentation in the form of an initial assessment and development of a treatment plan with established goals that must be present in the case record and must justify the need for service. Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered. A physical therapist must document each treatment note and must sign each note denoting whether or not progress is made. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the treatment plan.

(e) Services must be listed on the care plan and be provided and billed in 15-minute units of service. Physical therapy is limited to no more than 50 hours or 200 units for the initial plan.

(9) Positive Behavior Support Services

(a) Positive Behavior Support Services provides systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP for waiver recipients whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration, whose health is at risk, and/or

who may otherwise require movement to a more restrictive environment. Positive Behavior Support Services may include consultation provided to families, other caretakers, and habilitation services providers. Positive Behavior Therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

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

(c) The Positive Behavior Support Service has three service provider levels: two professional levels and one technical level, each with its own procedure code and rate of payment. The Positive Behavior Support Service levels are distinguished by the supervision requirements and qualifications of the provider. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

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

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

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

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

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

(f) The maximum units of Positive Behavior Support Services per year of both professional and technician

level units combined cannot exceed 1200 and the maximum units of service of professional level cannot exceed 800.

(g) Positive Behavior Support Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(10) Adult Companion Services

(a) Adult Companion Services are non-medical supervision and socialization, provided to a functionally impaired adult. Companions may assist the waiver recipient with such tasks as meal preparation, and shopping, but may not perform these activities as discrete services.

1. The provision of Adult Companion Services does not entail hands-on medical care.

2. Companions may perform light housekeeping tasks which are incidental to the care and supervision of the waiver recipient.

3. Adult Companion Services are provided in accordance with a therapeutic goal in the waiver recipient’s approved person-centered care plan and are not merely diversional in nature.

4. Adult Companion Services must be necessary to prevent institutionalization of the waiver recipient.

(b) Adult Companion Services can be self-directed to allow waiver recipients and their families to recruit, hire, train, supervise, and if necessary to discharge, their own workers. Self-Directed workers must adhere to all the traditional service rules. Payment may be made to legal liable relatives (i.e., the parent (biological or adoptive), guardian, spouse, or legally responsible relative) for furnishing Self-Directed Adult Companion services. The self-directed Adult Companion workers will be employed by the family and participant, who will be employers of record. A relative, including a legal liable relative, and/or a legal guardian may serve as a self-directed worker to a waiver participant for Adult Companion self-directed services as long as:

1. The relative/legal guardian is otherwise qualified to provide these services and

2. The relative/legal guardian does not also serve as the same participant’s representative/Employer of Record (EOR). The participant and, as applicable, the

participant's legal guardian, may designate another trusted individual as the representative/EOR.

(11) Respite Care Services

(a) Respite care is a service provided in or outside a family's home to temporarily relieve the primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day-to-day care giving for a dependent family member. Respite is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation.

(b) The limitation on either in-home or out-of-home Respite Care Services shall be provided up to a maximum of 1080 hours or 45 days per waiver recipient per waiver year.

(c) In-Home Respite Care Services can be self-directed, and the employer of record (EOR) may hire, supervise, or fire the employee delivering the services. A relative may serve as a self-directed respite worker to a waiver participant as long as

1. The relative is not a legally responsible individual or legal guardian,

2. The relative is not a primary caregiver to the participant,

3. The relative is otherwise qualified to provide these services and

4. The relative does not also serve as the same participant's representative/Employer of Record (EOR). The participant, EOR, and worker must be trained on identifying Abuse, Neglect and Exploitation, who to report to and the timeframes to report any incidents.

(d) Out-of-home respite care may be provided by a certified DDD provider. To receive self-directed Out-of-home respite services, a Certified DDD provider must be selected.

(e) Note that Waiver recipients will not reside in an adult foster care home, so there can be no duplication of billing for the two services.

(12) Personal Care Services

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

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

(c) Any relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the waiver recipient’s record by the provider agency. Siblings who do not reside in the home with the waiver recipient can be paid to provide Personal Care Services to the waiver recipient.

(d) Personal Care Services may be self-directed to allow waiver recipients and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers. Personal Care Services cannot be self-directed for children under the age of 21 on the State Plan. Payment may be made to legal liable relatives (i.e., the parent (biological or adoptive), guardian, spouse, or legally responsible relative) for furnishing Self-Directed Personal Care (and Personal Care transportation where applicable) services. The self-directed personal care workers will be employed by the family and participant, who will be employers of record. A relative, including a legal liable relative, and/or a legal guardian may serve as a self-directed worker to a

waiver participant for Personal Care self-directed services as long as

1. The relative/legal guardian is otherwise qualified to provide these services and

2. The relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR). The participant and, as applicable, the participant's legal guardian, may designate another trusted individual as the representative/EOR.

(e) Personal care is limited to no more than 12 hours/48 units each day for individuals living in the home with relatives or caregivers. The number of hours provided may exceed the 12 hours/48 per day for those individuals who live independently and assessed needs indicate the need for additional support and/or for participant whose hours need to exceed the 12 hours can be provided, but the approval should be based on the emergent need (i.e. illness or death of the primary caregiver). A record of the Personal Care visit will be captured by an Electronic Visit Verification Monitoring System.

(f) Personal Care Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan. Personal care cannot be provided in any group home or residential setting (i.e. residential habilitation) because the definition of residential habilitation is inclusive of personal care and would therefore be a duplication of services. This is not subject to due process.

(g) Personal Care Transportation

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

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

3. Personal Care Transportation shall not replace transportation that is already reimbursable under Day or Residential Habilitation Services. Personal Care Transportation is not intended to replace generic transportation nor to be used merely for convenience.

4. Personal Care Transportation Services may be self-directed to allow waiver recipients and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care transportation workers. Personal Care Transportation Services cannot be self-directed for children under the age of 21 on the State Plan. Payment may be made to legal liable relatives (i.e., the parent (biological or adoptive), guardian, spouse, or legally responsible relative) for furnishing Self-Directed Personal Care transportation. The self-directed personal care transportation workers will be employed by the family and participant, who will be employers of record. A relative, including a legal liable relative, and/or a legal guardian may serve as a self-directed worker to a waiver participant for Personal Care Transportation self-directed services as long as

(i) The relative/legal guardian is otherwise qualified to provide these services and

(ii) The relative/legal guardian does not also serve as the same participant's representative/ Employer of Record (EOR). The participant and, as applicable, the participant's legal guardian, may designate another trusted individual as the representative/EOR.

(13) Environmental Accessibility Adaptations Services

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

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

(c) Environmental Accessibility Adaptations Services may be directed by waiver recipients or family but must adhere to all the traditional service rules. Self-Directed Environmental Accessibility Adaptations are only available to those participants who are self-directing personal care and/or LPN/RN services.

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

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

(14) Specialized Medical Supplies Services

(a) Specialized Medical Supplies Services provide supplies that are necessary to maintain the waiver recipient’s health, safety, and welfare and to prevent further deterioration of a condition or increase an individual’s ability to perform activities of daily living. This includes personal protective equipment (PPE). These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

(b) Specialized Medical Supplies Services will only be provided when authorized by the waiver recipient’s physician and shall meet applicable standards of

manufacturer, design and installation. Providers of Specialized Medical Supplies Services will be those who have a signed provider agreement with Medicaid and ADMH. Written orders from a physician or other licensed health care provider for non-prescription assistive technology items authorized in an individual's person-centered plan is required. Providers of this service must maintain documentation of items purchased for each individual, including the receipt of any verbal orders. Specialized Medical supplies are limited to a maximum of $2,400.00 per waiver recipient per year. The operating agency must maintain documentation of items purchased for the waiver recipient. All items shall meet applicable standards of manufacture and design.

(c) Specialized Medical Supplies Services may be directed by waiver recipients or family but must adhere to all the traditional service rules. Specialized Medical Supplies Services cannot be self-directed for children under the age of 21 under the State Plan.

(d) Specialized Medical Supplies Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(e) Self-directed medical supplies services are available only to those participants who are also self-directing personal care and/or LPN/RN services.

(15) Skilled Nursing Services

(a) Skilled Nursing Services are services listed in the waiver recipient’s approved person-centered care plan which are within the scope of the Alabama Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled Nursing Service consists of nursing procedures that meet the waiver recipient’s health needs as ordered by a physician. Skilled Nursing Services will be billed by the hour. There is no restriction on the place of Skilled Nursing Services.

(b) Skilled Nursing Services may also be self-directed when provided to a waiver recipient participant or family, which is self-directing Personal Care Services. Personal Care Services include training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker.

(c) Skilled Nursing Services cannot be self-directed for children under the age of 21 under the State Plan.

(d) Skilled Nursing Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

(16) Assistive Technology Services

(a) Assistive Technology Services means an item or piece of equipment (including any equipment not covered by Medicaid State Plan Services), service animal or product system, whether acquired commercially, modified or customized that is used to increase, maintain, or improve functional capabilities of participants. Assistive Technology Services means a service that directly assist an individual in the selection, acquisition, or use of an assistive technology device.

(b) Written orders from a physician or other licensed health care provider for non-prescription assistive technology items authorized in an individual's person-centered plan is required. Providers of this service must maintain documentation of items purchased for each individual, including the receipt of any verbal orders. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. Costs are limited to $5,000 per waiver recipient, per year.

(c) Assistive Technology Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(d) Assistive Technology Services may be directed by waiver recipients or family but must adhere to all the traditional service rules. Assistive Technology Services cannot be self-directed for children under the age of 21 under the State Plan.

(e) Self-Directed Assistive Technology is only available to those participants who are self-directing Personal Care, Adult Companion and/or Skilled LPN/RN services.

(17) Crisis Intervention Services

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

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

(c) Individuals with intellectual disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises.

(d) Crisis Intervention Services are expected to be of brief duration (10 weeks, maximum). When Crisis Intervention Services of a greater duration are required, the waiver recipient shall be transitioned to a more appropriate service program or setting.

(e) Crisis Intervention Services providers shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Alabama and meeting the requirements of a QDDP (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving individuals with intellectual disabilities and have a minimum of 40 hours training in crisis intervention techniques prior to providing Crisis Intervention Services.

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

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

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

(i) All Crisis Intervention Services shall be approved by the regional community service office of the ADMH prior to the service being initiated.

(j) Specific Crisis Intervention Services components may include the following:

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

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

3. Developing and writing an intervention plan;

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

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

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

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

(k) Crisis Intervention Services under the waiver are not available to children under the age of 21 when provided as the result of an EPSDT screening, because this service is covered under the State Plan.

(18) Benefits and Career Counseling Services

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

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

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

(b) The Benefits Counselor must be a Certified Work Incentives Counselor (CWIC) through a recognized training by the Social Security Administration for delivery of Career Counseling Services. This may include a level 5 security clearance from the Social Security Administration/Department of Homeland Security due to Personally Identifiable Information.

(19) Community Experience Services

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

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

1. Community Experience Individual Services are provided to a waiver recipient, with a one-to-one

staff to waiver recipient ratio which is determined necessary through functional and health risk assessments prior to approval. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval.

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

(c) Transportation to and from activities and settings is a component of this service. Transportation is provided by the agency responsible for the service or by staff/ family/or other natural support. Transportation provided through Community Experience Services is included in the cost of doing business and incorporated in the rate.

(d) Community Experience Services cannot be provided in the participant's home or during the same time the participant is receiving Residential Habilitation since community integration is part of that service. Community Experience Group should not be used to facilitate group activities that normally would be provided by the Day Habilitation provider.

(20) Housing Stabilization Services

(a) The Housing Stabilization Service enables waiver recipients to maintain their own housing as set forth in the waiver recipient's approved person-centered care plan. Housing Stabilization Services must be provided in the home or a community setting. Housing Stabilization Services include the following components:

1. Conducting a Housing Coordination and Stabilization Assessment identifying the waiver recipient's preferences related to housing and needs for support to maintain housing, budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.

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

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

4. Developing an individual housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person-Centered Plan.

5. Participating in waiver recipient's Person-Centered Plan meetings at redetermination and/or revision plan meetings as needed.

6. Providing supports and interventions per the waiver recipient's Person-Centered Plan (individualized housing stabilization portion).

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

8. If at any time the waiver recipient's housing is placed at risk (e.g., eviction, loss of roommate, or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community-based supports which includes locating new housing, sources of income, etc.

(21) Individual Directed Goods and Services

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

(b) Individual Directed Goods and Services are required to meet the identified needs and outcomes in the waiver recipient's Person Centered Plan, or the most cost effective to meeting the assessed need, assures health, safety, and welfare, and are directly beneficial to the waiver recipient in achieving at least one of the following outcomes: Improved cognitive, social, or behavioral functioning; maintain the waiver recipient's ability to remain in the community; enhance inclusion and

family involvement; develop or help maintain personal, social, or physical skills; decrease dependency on formal supports services, and increase independence.

(c) The limit on the amount of Goods and Services that can be purchased is determined individually based on the balance of the waiver recipient's saving account at the time of the request, which is maintained by the Financial Management Services Agency, but not to exceed $10,000 annually.

(22) Supported Employment Transportation Services

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

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

(23) Personal Emergency Response System Services

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

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

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

(24) Remote Support Services

(a) Remote Support Services are services provided to recipients who are 18 years of age or older, at their place of residence, by Remote Support staff housed at a remote location and who are engaged with the recipient through equipment with the capability for live, two-way communication.

(b) Remote Support Services shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using an appropriate, stable, and reliable electronic connection.

(c) Remote Support Services are intended to address a person's assessed needs in his/her residence and are to be provided in a manner that promotes autonomy, minimizes dependence on paid support staff, and reduces the need for in-person services that may be more intrusive.

Author: Riyyah James, Associate Director, Specialized Waiver Unit, LTC Healthcare Reform Development Division
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for the Persons with Intellectual Disabilities.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed December 9, 1996; effective January 14, 1997. **Amended:** February 5, 2001; effective March 12, 2001. **Amended:** Filed May 12, 2005; effective June 16, 2005. **Amended:** Filed January 11, 2008; effective February 15, 2008. **Amended:** Filed March 13, 2009, effective April 17, 2009. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Filed September 11, 2018; effective October 26, 2018. **Amended:** Published January 31, 2020; effective March 16, 2020. **Amended:** Published August 31, 2021; effective October 15, 2021. **Amended:** Published May 31, 2022; effective July 15, 2022. **Amended:** Published June 30, 2025; effective August 14, 2025. **Amended:** Published May 29, 2026; effective July 13, 2026.

560-X-35-.03 Eligibility.

Eligibility criteria for Home and Community-Based Services (HCBS) recipients under the Waiver for Persons with Intellectual Disabilities (ID Waiver) shall be the same as eligibility criteria for an intermediate care facility for individuals with intellectual disabilities (ICF/IID). Thus, HCBS under the ID Waiver will be available to persons with intellectual disabilities who would be eligible for institutional services under 42 C.F.R. §435.217 and who are now eligible under 435.120. Persons with intellectual disabilities who meet categorical (including 42 C.F.R. §435.120), medical, and/or social requirements for Title XIX coverage will be eligible for HCBS under the ID Waiver. Applicants found eligible shall not be required to apply income

above the personal needs allowance reserved to institutional recipients toward payment of care.

(1) Financial eligibility for HCBS under the ID Waiver is limited to those individuals receiving SSI, Parent and Other Caretaker Relatives (POCR), Pregnant Women, Infants and Children under Age 19, Children with Non IV-Adoption Assistance (Over age 21), Children with Non IV-Adoption Assistance, Former Foster Care, Reasonable Classification of Individuals under Age 21, SSI related protected groups deemed to be eligible for SSI/Medicaid (i.e., Widow/Widower, Disabled Adult Child, Continuous (Pickle) Medicaid), federal and state adoption subsidy individuals, and special home and community-based optional categorically needy group whose income is not greater than 300 percent of the SSI federal benefit rate.

(2) Medical eligibility for HCBS under the ID Waiver is limited to those individuals that meet the ICF/IID level of care. No HCBS under the ID Waiver will be provided to a recipient residing in an institutional facility, or who has a primary diagnosis of mental illness, or whose health and safety is at risk in the community.

(3) Financial determinations and redeterminations for HCBS under the ID Waiver shall be made by the Alabama Medicaid Agency, the Department of Human Resources or the Social Security Administration, as appropriate. In addition to the financial and medical eligibility criteria, the Alabama Medicaid Agency is limited to the number of recipients who can be served by the ID Waiver.

Author: Samantha McLeod, Associate Director, LTC Specialized WaiverProgram
Statutory Authority: 42 C.F.R. §§441, Subpart G; Home- and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Repealed and Replaced:** Filed December 9, 1996; effective January 14, 1997. **Amended:** Filed August 11, 2003; effective September 15, 2003. **Amended:** Filed December 10, 2004; effective January 14, 2005. **Amended:** Filed May 12, 2005; effective June 16, 2005. **Amended:** Filed March 12, 2010; effective April 16, 2010. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Published January 31, 2020; effective March 16, 2020.

560-X-35-.04 Characteristics Of Persons Requiring ICF/IID Care.

(1) Generally, persons eligible for the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are those persons who need such level of care because the severe, chronic nature of their mental impairment

results in substantial functional limitations in three or more of the following areas of life activity:

Self-Care

Receptive and expressive language

Learning

Self-direction

Capacity for independent living

Mobility

(2) Services provided in an ICF/IID in Alabama are those services that provide a setting appropriate for a functionally individual with an intellectual disability in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/IID care is made by a Qualified Developmental Disabilities Professional (QDDP). A QDDP is an individual possessing, at minimum, those qualifications in 42 C.F.R. Section 483.430. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a QDDP and a physician.

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

Author: Riyyah James, Associate Director, Specialized Waiver Unit, LTC Healthcare Reform Development Division

Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for Persons with Intellectual Disabilities.

History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** February 5, 2001; effective March 12, 2001. **Amended:** Filed May 12, 2005; effective June 16, 2005. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Published May 29, 2026; effective July 13, 2026.

560-X-35-.05 Qualifications Of Staff Who Will Serve As Review Team For Medical Assistance.

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

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

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

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

(a) Special Education

(b) Speech Pathologist

(c) Audiologist

(d) Physical Therapist

(e) Optometrist

(f) Occupational Therapist

(g) Vocational Therapist

(h) Recreational Specialist

(i) Pharmacist

(j) Doctor of Medicine

(k) Psychiatrist

(l) Other skilled health professionals

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs

Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed July 12, 2017; effective August 26, 2017.

560-X-35-.06 Financial Accountability (Repealed 7/17/12).

(REPEALED)
Author: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R. §441; 45 C.F.R. Part 95; OMB Circular A-87, Subpart G; Home- and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, November 10, 1988, June 6, 1990. **Amended:** Filed December 9, 1996; effective January 14, 1997. **Amended:** Filed December 10, 2004; effective January 14, 2005. **Amended:** Filed March 13, 2009; effective April 17, 2009. **Repealed:** Filed June 12, 2012; effective July 17, 2012.

560-X-35-.07 Individual Assessments.

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

(2) The Alabama Medicaid Agency will give notice of services available under the waiver as required by federal regulations, particularly to primary care givers for the target group,

including but not limited to, programs operated by Alabama Department of Mental Health, the statewide network of community mental health centers, and to other appropriate care-giving agencies such as county department of human resources offices, hospitals, hospital associations, and associations for individuals with intellectual disabilities.
Author: Riyyah James, Associate Director, Specialized Waiver Unit, LTC Healthcare Reform Development Division
Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Published May 29, 2026; effective July 13, 2026.

560-X-35-.08 Informing Beneficiaries Of Choice.

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

(2) Residents of long-term care facilities for whom home- and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of review. Applicants for SNF, ICF, ICF/IID services, or a designated responsible party with authority to act on the applicant's behalf, will be advised of feasible alternatives to institutionalization at the time of their entry into a treatment system wherein an alternative is professionally determined to be feasible. All applicants found eligible for home- and community-based services will be offered the alternative unless there is reasonable expectation that services required for the applicant would cost more than institutional care. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.
Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed July 12, 2017; effective August 26, 2017.

560-X-35-.09 Payment Methodology For Covered Services.

(1) The Medicaid reimbursement for each service provided by a mental health service provider shall be based on a fee-for-service system. Each covered service is identified on a claim by a procedure code.

(2) Providers should bill no more than one month's services on a claim for a recipient. There may be multiple claims in a month, but no single claim may cover services performed in different months. For example, October 15, 1990, to November 15, 1990, would not be allowed. If the submitted claim covers dates of service, part or all of which were covered in a previously paid claim, it will be rejected.

(3) Payment will be based on the number of units of service reported for HCPCS codes.

(4) All claims for services must be submitted within 12 months from the date of service.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on HCFA's form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by a direct service provider agency is reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for persons with Intellectual Disabilities.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed December 9, 1996; effective January 14, 1997. **Amended:** February 5, 2001; effective March 12, 2001. **Amended:** Filed October 21, 2004;

effective January 14, 2005. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-35-.10 Third Party Liability.

Providers shall make all reasonable efforts to determine if there is a liable third-party source, including Medicare, and in the case of a liable third-party source, utilize that source for payments and benefits prior to applying for Medicaid payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency.
Author: Willie J. Johnson
Statutory Authority: 42 C.F.R., §441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990.

560-X-35-.11 Payment Acceptance.

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

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

(3) No person or entity, except a liable third-party source, shall be billed for covered Medicaid services.
Author: Willie J. Johnson
Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990.

560-X-35-.12 Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction.
Author: Willie J. Johnson

Statutory Authority: 42 C.F.R. §§441, Subpart G; Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990.

560-X-35-.13 Records.

(1) The Department of Mental Health shall make available to the Alabama Medicaid Agency at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent of services shall be maintained by the clinic. Said records shall be retained for the period of time required by state and federal laws.

(2) Sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature.
Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: 42 C.F.R. §441, Subpart G; Home- and Community-Based Waiver for Persons with Intellectual Disabilities.
History: Rule effective July 9, 1985. **Amended:** effective November 18, 1987, June 6, 1990. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-35-.14 Service Providers.

The Home and Community-Based ID Waiver is a cooperative effort between the Alabama Medicaid Agency and the Department of Mental Health.
Author: Samantha McLeod, Associate Director, LTC Specialized Waiver Programs
Statutory Authority: The Home- and Community-Based Waiver for Persons with Intellectual Disabilities.
History: New Rule: Filed December 9, 1996; effective January 14, 1997. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-35-.15 Application Process.

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

(2) The operating agency will review the applicant's eligibility status to determine if the applicant is medically and financially eligible for waiver services. The targeted case manager will assist the recipient to make financial application and ensure that the appropriate documents are completed and routed to the appropriate Medicaid District Office.

(3) All recipients who are applying for an HCBS waiver who are financially approved by the Department of Human Resources or are under the age of 65 and have not been determined disabled must have a disability determination made by the Medical Review team of the Alabama Medicaid Agency.

(4) If a disability determination has been made, the Regional Office should complete a slot confirmation form (Form 376).

(5) The Qualified Developmental Disabilities Professional (QDDP) will complete the level of care determination and the plan of care development.

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

(7) During the assessment, it must be determined that "without waiver services the client is at risk of institutionalization."

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

(9) The Alabama Department of Mental Health (ADMH) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the Home and Community-Based Waiver for Persons with Intellectual Disabilities.

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

(11) The ADMH will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

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

(13) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Home and Community Based Waiver for Persons with Intellectual Disabilities to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met. The LTC Waiver Quality Improvement Unit conducts a random sample of plans of care and related documents annually.

(14) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(15) The Alabama Medicaid Agency may seek recoupment from ADMH for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for the Home and Community-Based Waiver for Persons with Intellectual Disabilities or Medicaid eligibility but for the certification of waiver eligibility by ADMH.

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

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

(18) If Medicaid’s Fiscal Agent accepts the transmission, the information is automatically written to the Long-Term Care file. The operating agency or its designee can begin rendering services and billing the Alabama Medicaid Agency for services rendered.

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

(20) Neither the Alabama Medicaid Agency nor Medicaid’s Fiscal Agent will send out the LTC-2 Notification letters. The record of successful transmission will be your record of “approval” to begin rendering service.

(21) For applications where the level of care is questionable, you may submit the applications to the LTC Medical and Quality Review Unit for review by a nurse and/or a Medicaid physician.

(22) Once the individual's information has been added to the Long-Term Care File, changes can only be made by authorized Medicaid staff.
Author: Riyyah James, Associate Director, Specialized Waiver Unit, LTC Healthcare Reform Development Division
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: New Rule: Filed December 9, 1996; effective January 14, 1997. **Repealed and New Rule:** Filed July 14, 2003; effective August 18, 2003. **Amended:** Filed December 10, 2004; effective January 14, 2005. **Amended:** Filed January 11, 2008; effective February 15, 2008. **Amended:** Filed June 12, 2012; effective July 17, 2012. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Published May 29, 2026; effective July 13, 2026.

560-X-35-.16 Cost For Services.

The cost for services to individuals who qualify for Home and Community-Based care under the waiver program will not exceed on an average per capita basis the total expenditures that would be incurred for such individuals if Home and Community-Based services were not available.
Author: Mattie Jackson, Director, LTC Healthcare Reform Development Division
Statutory Authority: 42 C.F.R. Section 441, Subpart G; and the Home and Community-Based Waiver for Persons with Intellectual Disabilities.
History: New Rule: Filed December 9, 1996; effective January 14, 1997. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-35-.17 Fair Hearings.

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

(2) If an individual/guardian chooses to appeal an adverse decision, they may choose to appeal to the Department of Mental Health (DMH) Associate Commissioner of the Developmental Disabilities Division no later than 15 calendar days after the effective date printed on the Notice of Action.

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

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

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

(4) Upon receipt of an appeal request by the DMH Associate Commissioner of the Developmental Disabilities Division, contact is made with the Regional Community Services Offices to request the information packet that they reviewed to base the denial decision. The DMH Associate Commissioner of the Developmental Disabilities Division will contact the individual/guardian and inform them that the division is in the process of reviewing their information. A written decision from the DMH Associate Commissioner will be mailed (certified) to the individual/guardian within 21 days after the review of all information is completed. If the individual/guardian disagrees with the DMH Associate Commissioner's decision, he/she can submit a request for a Fair Hearing to the Alabama Medicaid Agency (Medicaid). A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the DMH Associate Commissioner's response letter.
Author: Mattie Jackson, Director, LTC Healthcare Reform Division
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 431, Subpart E-Fair Hearings for Applicants and Recipients.
History: New Rule: Filed December 9, 1996; effective January 14, 1997. **Amended:** Published January 31, 2020; effective March 16, 2020. **Amended:** Published March 31, 2022; effective May 15, 2022. **Amended:** Published March 31, 2023; effective May 15, 2023.

560-X-35-.18 Appeal Procedure (Fiscal Audit) (Repealed 4/13/09).

(Repealed)
Author: Laura Walcott, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: New Rule: Filed December 9, 1996; effective January 14, 1997. **Amended:** Filed December 10, 2004; effective January 14, 2005. **Repealed:** Filed March 13, 2009; effective April 17, 2009.