ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-52
HOME AND COMMUNITY-BASED LIVING AT HOME (LH) WAIVER FOR THE MENTALLY RETARDED

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560-X-52-.01 Authority And Purpose.

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

(2) The HCBS covered in the LAH Waiver are Community Day Habilitation Services, Day Habilitation Services, Prevocational Services, Supported Employment Services, Occupational Therapy Services, Speech and Language Therapy Services, Physical Therapy Services, Positive Behavior Support Services, Respite Care Services, Personal Care Services, Environmental Accessibility Adaptations Services, Specialized Medical Supplies Services,

Assistive Technology Services, Skilled Nursing Services, Crisis Intervention Services, Individual Directed Goods and Services, Assistance in Community Integration Services, Benefits and Career Counseling Services, Community Experience Services, Personal Emergency Response System (PERS) Services, Supported Employment Transportation Services, Remote Support Services, Adult Companion Services, Supported Living Services, and Housing Stabilization Services. These HCBS provide assistance necessary to ensure optimal functioning of individuals with intellectual disabilities.

(3) The LAH Waiver is administered through a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and is restricted to individuals with a diagnosis of an intellectual disability, ages 3 and above, and those not residing in a group home situation. Priority access to the LAH Waiver shall be given to individuals on a verified waiting list.

(4) Home and Community-Based Services for the LAH 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-52-.02 Description of Services.

Home and Community-Based Services (HCBS) under the Home and Community-Based Living at Home (LAH) Waiver for Persons with Intellectual Disabilities are defined as Title XIX Medicaid-funded services provided to Revised 5\15\22 52-2individuals with intellectual disabilities who, without these services, would require services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). These HCBS under the LAH Waiver will provide health, social, and related support needed to ensure optimal functioning of individuals with intellectual disabilities within a community setting. The operating agency may provide or subcontract for any services provided in this waiver. To qualify for Medicaid reimbursement each individual HCBS must be necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as HCBS under the

LAH Waiver. The following are specific HCBS available under the LAH Waiver:

(1) 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.

(2) 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 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).

(3) 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 target service designed to help a waiver recipient who wishes to pursue individualized, integrated employment or self-employment. Discovery may involve a comprehensive analysis of the waiver recipient's history; interviews with family, friends and support staff; observing the waiver recipient performing work skills; and career research in order to determine the waiver recipient's career interests, talents, skills, support needs and choice; and the writing of a 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 support to waiver recipients obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which a waiver recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Employment Individual includes two distinct services: Job Developer and Job Coach.

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

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

(b) Supported Employment Services are conducted in a variety of settings, particularly, work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by waiver recipients, including supervision and training.

(c) When Supported Employment Services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities. Payment for the supervisory activities rendered as a normal part of the business setting will not be made.

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

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

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

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

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

(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 habilitation services in more than one place) as a component part of

habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

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

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

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

(4) Occupational Therapy Services

(a) Occupational Therapy Services are the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. Occupational Therapy Services include assisting in the evaluation of a waiver recipient to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating waiver recipients in the prescribed therapy to secure and/or obtain necessary functioning.

(b) Therapists may also provide consultation and training to staff or caregivers (such as waiver recipient’s family and/or foster family). 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 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.

(6) Speech and Language Therapy Services

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

(b) These services may include:

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

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

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

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

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

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

(d) Speech and Language Therapy Services must be listed on the care plan and prescribed by 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 for

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.

(e) Speech and Language Therapy Services are covered under the State Plan for eligible waiver recipients as a result of an EPSDT screening. Therefore, this service is limited to waiver recipients age 21 and over. Group therapy will not be reimbursed.

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

(6) 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. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and

2. Prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

(b) Therapists may also provide consultation and training to staff or caregivers (such as waiver recipient’s family and/or foster family). 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 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.

(d) 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.

(7) Positive Behavior Support Services

(a) Positive Behavior Support Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for waiver recipients whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Positive Behavior Support Services may include consultation provided to families, other caretakers, and habilitation services providers. Positive Behavior Support Services shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

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

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

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

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

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

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

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

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

(g) Positive Behavior Support Services 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.

(8) 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 Services may be provided by a certified DDD provider. To receive self-directed Out-of-home 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.

(9) Personal Care Services

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

(b) Personal Care Services under the Living at Home Waiver may also include general supervision and protective oversight reasonable to the accomplishment of health, safety and inclusion. The worker may directly perform some activities and support the individual in learning how to perform others; the planning team (composed at minimum of the person and family, and a support coordinator) shall determine the composition of the Personal Care Service and assure it does not duplicate, nor is duplicated by, any other service provided to the waiver recipient.

(c) A written description of what the personal care worker will provide to the waiver recipient is required to be submitted to the state as part of or in addition to the waiver recipient's approved person-centered care plan and will require approval by the Division of Developmental Disabilities and be subject to review by the Single State Agency for Medicaid.

(d) Personal Care Services cannot be provided in any group home or other residential setting (i.e., residential habilitation).

(e) The person-centered care plan or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the waiver recipient. Parents and other caretakers shall be key informers on the matter of special training and will be encouraged to participate in the training and supervision of the worker.

(f) When Personal Care Services are provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the waiver recipient's documented need for Personal Care Services as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

(g) There is no restriction on the place of service so long as the waiver recipient is eligible for the LAH Waiver in that setting and no duplication of payment occurs. This would preclude personal care being provided in, for instance, a day habilitation or respite setting where payment would already be made for the same services. Payment is for a 15-minute unit of service, not including worker's time of travel to and from the place of work.

(h) 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.

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

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

(k) Personal Care Transportation

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

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

3. Personal Care Transportation shall not replace transportation that is already reimbursable under Day or Residential Habilitation Services nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

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 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 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.

(10) Environmental Accessibility Adaptations Services

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

(d) Environmental Accessibility Adaptations Services may be directed by waiver recipients or family but must

adhere to all the traditional service rules. Self-Directed Environmental Accessibility Adaptations are only available to those participants who are self-directing personal care and/or LPN/RN services.

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

(11) 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. Specialized Medical Supplies Services 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.

(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.

(12) 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.

(13) 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 State’s Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

(b) Skilled Nursing Services consist of nursing procedures that meet the waiver recipient’s health needs as ordered by a physician.

(c) Skilled Nursing Services will be billed by the hour. There is no restriction on the place of service.

(d) Skilled Nursing Services may also be self-directed when provided to a waiver recipient or family which is self-directing Personal Care Services. Skilled Nursing 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.

(14) 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 her 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) Crisis Intervention Services will not count against the $58,000 per waiver recipient per year cap in the LAH Waiver, since the need for the Crisis Intervention Service cannot accurately be predicted and planned for ahead of time.

(k) Specific Crisis Intervention Service components may include the following:

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

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

3. Developing and writing an intervention plan;

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

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

(l) These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

(15) Individual Directed Goods and Services

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

(b) 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.

(16) Assistance in Community Integration Services

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

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

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

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

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

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

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

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

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

(17) 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.

(18) 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.

(19) Personal Emergency Response System (PERS) Services

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

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

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

(20) Supported Employment Transportation Services

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

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

(21) 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.

(22) 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.

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

8. 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.

(24) 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.

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

Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.

History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed May 11, 2007; effective June 15, 2007. **Amended:** Filed January 7, 2009; effective February 11, 2009. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Filed November 9, 2018; effective December 24, 2018. **Amended:** Published August 31, 2021; effective October 15, 2021. **Amended:** Published June 30, 2025; effective August 14, 2025. **Amended:** Published May 29, 2026; effective July 13, 2026.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.03 Eligibility.

Medical eligibility for HCBS under the LAH Waiver is limited to those individuals that meet the ICF/IID level of care. No HCBS under the LAH Waiver will be provided to a recipient residing in an institutional facility, or who has a primary diagnosis of mental illness, or whose health and safety is at risk in the community. Thus, HCBS under the LAH Waiver will be available to persons with intellectual disabilities who would be eligible for institutional services under 42 C.F.R. §435.217.

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

Individuals receiving SSI.

SSI related protected groups deemed to be eligible for SSI/ Medicaid (i.e., Widow/Widower, Disabled Adult Child, Continuous (Pickle) Medicaid).

Parent and Other Caretaker Relatives (POCR).

Federal and State adoption subsidy individuals.

Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

Persons with intellectual disabilities who meet categorical (including 42 C.F.R. §435.120), medical, and/or social requirements for Title XIX coverage will be eligible for HCBS under the LAH waiver. Applicants found eligible shall not be required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care.
Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed January 7, 2009; effective February 11, 2009. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Filed November 9, 2018; effective December 24, 2018.

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560-X-52-.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 intellectual disabilities in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/IID care is made by a Qualified Developmental Disability Professional (QDDP). A QDDP is an individual possessing, at minimum, those qualifications in 42 C.F.R. Section 442.401. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a 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: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.

History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Published May 29, 2026; effective July 13, 2026.

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560-X-52-.05 Qualifications Of Staff Who Will Serve As Review Team For Medical Assistance.

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

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

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

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

(a) Special Education,

(b) Speech Pathologist,

(c) Audiologist,

(d) Physical Therapist,

(e) Optometrist,

(f) Occupational Therapist,

(g) Vocational Therapist,

(h) Recreational Specialist, Revised 5\15\22 52-30

(i) Pharmacist,

(j) Doctor of Medicine,

(k) Psychiatrist, and

(l) Other skilled health professionals
Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed July 12, 2017; effective August 26, 2017.

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560-X-52-.06 Financial Accountability.

The financial accountability of providers for funds expended on home and community-based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients through the renewal period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the State of Alabama, the provider will pay all travel costs of the auditors to the location of the records.
Author: Felecia Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002.

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560-X-52-.07 Individual Assessments.

(1) Alabama Medicaid Agency will require an individual plan of care for each waiver service recipient. Such plan, entitled "Person-Centered Plan" (PCP), is subject to review by the Alabama Medicaid Agency and Department of Health and Human Services. The Alabama Medicaid Agency will review recipients' habilitation and care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures. Client assessment procedures in place in the Alabama Department of Mental Health, which are based on eligibility criteria for ICF/IIDs developed jointly by DMH and the Alabama Medicaid Agency, will be utilized by the Department of Mental Health (or its contract service providers) in screening for

eligibility for the waiver services as an alternative to institutionalization. Whether performed by a qualified practitioner in the Department of Mental Health, its contract service providers, or provided by qualified (Diagnostic and Evaluation Team) personnel of the individual/agency arranging the service, review for "medical assistance" eligibility determination will be based on client assessment data, and the criteria for admission to an ICF/IID, as described in Rule No. 560-X-52-.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: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Published June 30, 2025; effective August 14, 2025. **Amended:** Published May 29, 2026; effective July 13, 2026.

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560-X-52-.08 Informing Beneficiaries Of Choice.

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

(2) Residents of long-term care facilities for whom home and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of medical review. Applicants for SNF, ICF, ICF/IID services, or a designated responsible party with authority to act on the applicant's behalf, will be advised of feasible alternatives to institutionalization at the time of their entry into a treatment system wherein an alternative is professionally determined to be

feasible. All applicants found eligible will be offered the alternative unless there is reasonable expectation that services required for the applicant would cost more than institutional care. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.
Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.09 Payment Methodology For Covered Services.

(1) Actual reimbursement will be based on the rate in effect on the date of service.

(2) Rates will be established and reported to the Alabama Medicaid Agency's fiscal agent for claims submitted for payment.

(3) Payment will be based on the number of units of service reported for each HCPC code.

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

(5) Accounting for actual cost and units of services provided during a waiver year must be captured on the CMS 372 Report.
Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed October 12, 2004; effective November 16, 2004. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.10 Payment Acceptance.

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

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

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services.
Author: Felecia Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.11 Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction.
Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.12 Records.

(1) The Department of Mental Health shall make available to the Alabama Medicaid Agency at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and

utilization review by duly authorized representatives of federal and state agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent services shall be maintained by the clinic. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log complete with the date and nature of services provided must be signed by the recipient. If the recipient is unable to sign, the signature must be obtained by the responsible guardian/caregiver.
Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed June 11, 2014; effective July 16, 2014.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.13 Provider Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider agreements to applicants who meet the licensure and/or certification requirements of the state Alabama of Alabama, the Code of Federal Regulations and the Medicaid Provider Manual.

(2) General enrollment instructions and information can be found in Chapter 2, "Becoming a Medicaid Provider", of the Alabama Medicaid Provider Manual. Failure to provide accurate and truthful information or intentional misrepresentation may result in action ranging from denial of application to permanent exclusion.
Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 431, Subpart E Fair Hearings for Applicants and Recipients.
History: New Rule: Filed November 21, 2002; effective December 26, 2002.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.14 Cost For Services.

(1) The cost for services to individuals who qualify for home and community-based care under the waiver program will not exceed a

cap of $58,000 per client per year with the exception that crisis intervention services are not included in the cap. Further, the waiver program will not exceed on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.
Author: Riyyah James, Associate Director, Specialized Waiver Unit, LTC Healthcare Reform Development Division
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed November 21, 2002; effective December 26, 2002. **Amended:** Filed January 7, 2009; effective February 11, 2009. **Amended:** Published June 30, 2025; effective August 14, 2025.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.15 HCBS Waiver Appeal Process.

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

(2) If an individual/guardian chooses to appeal an adverse decision, they may choose to appeal 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 of one of Federal or State law or policy; and

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

(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 November 21, 2002; effective December 26, 2002. **Repealed and New Rule:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Published March 31, 2022; effective May 15, 2022. **Amended:** Published March 31, 2023; effective May 15, 2023.

Ed. Note: Entire chapter was repealed as per certification filed December 7, 1995; effective January 11, 1996.

560-X-52-.16 Application Process.

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

(2) The operating agency will review the applicant's eligibility status to determine if the applicant is medically eligible for waiver services. The target case manager will assist the recipient to make financial application and ensure that the appropriate documents are completed and routed to the appropriate Medicaid District Office if the individual is not already eligible and enrolled in an applicable Medicaid aid category. Financial eligibility must be certified by Medicaid.

(3) The Waiver Coordinator will complete the level of care determination and the case manager will develop the plan of care.

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

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

(6) The Alabama Department of Mental Health (ADMH) is responsible for the assessment, evaluation of admissions, readmissions, and

annual redeterminations for eligible participants receiving home and community based services in accordance with the provisions of the Living at Home Waiver.

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

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

(9) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Living at Home Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met. The Waiver Quality Assurance Unit conducts a 5% sample of plans of care and related documents annually for each provider.

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

(11) The Alabama Medicaid Agency may seek recoupment from ADMH/MR for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for the Living at Home Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADMH.

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

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

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

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

(16) Neither the Alabama Medicaid Agency nor Medicaid's Fiscal Agent will send out the LTC-2 Notification letters. The record of successful transmission will be the record of "approval" to begin rendering service.

(17) For applications where the level of care is questionable, providers may submit the applications to the Long Term Care Quality Assurance Unit for review by a nurse and/or a Medicaid physician.

(18) Once the individual's information has been added to the Level of Care File, changes can only be made by authorized Medicaid staff.

Author: Samantha McLeod, Associate Director, Long Term Care Specialized Waiver Programs

Statutory Authority: Social Security Act §1915(c); 42 C.F.R. -Section 441, Subpart G Home and Community-Based Services: Waiver Requirements.

History: New Rule: Filed July 14, 2003; effective August 18, 2003. **Amended:** Filed May 11, 2007; effective June 15, 2007. **Amended:** Filed June 11, 2014; effective July 16, 2014.