ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-54
HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS UNDER THE TECHNOLOGY ASSISTED (TA) WAIVER FOR ADULTS

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560-X-54-.01 Authority And Purpose.

(1) Home and community-based services for the Technology Assisted Waiver for Adults are provided by the Alabama Medicaid Agency to individuals with disabilities who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of three (3) years and for five (5) year periods thereafter upon renewal of the waiver by the Centers for Medicare and Medicaid Services (CMS).

(2) The purpose of providing home and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

(3) Home and Community-Based Services for the TA 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; and

5. Facilitate choice regarding services and who provides them.

(b) 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; and,

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.

Author: Jessie Burris, Associate Director, LTC Healthcare Reform Division
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 441, Subpart G.
History: New Rule: File May 12, 2003; effective June 16, 2003.
Amended: Published March 31, 2023; effective May 15, 2023.

560-X-54-.02 Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, SSI related protected groups deemed to be eligible for SSI/Medicaid (widow/widower, Disabled Adult Child, Continuous (Pickle) Medicaid) and special home and community-based optional categorically needy group whose income is not greater than 300 percent of the SSI federal benefit rate.

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10. In addition, waiver services are limited to those individuals with complex skilled medical conditions who have

a medical history of being ventilator-dependent or who have a tracheostomy.

(3) No waiver services will be provided to recipients in a hospital or nursing facility.

(4) The Alabama Medicaid Agency may also deny home and community-based services if it is determined that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual fail to meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by the Centers for Medicare and Medicaid Services.

(6) The eligibility age criteria is 21 years and above.
Author: Ginger Wettingfield, Director LTC Healthcare Reform Division
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: New Rule: File May 12, 2003; effective June 16, 2003. **Amended:** Filed August 11, 2008; effective September 15, 2008. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed June 11, 2018; effective July 26, 2018.

560-X-54-.03 Covered Services.

(1) Personal Care/Attendant Services.

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

(b) PC/AS is designed to increase an individual’s independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

(c) PC/AS is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

(2) Private Duty Nursing.

(a) The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform his/her duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized.

(b) Private Duty Nursing Services are not an entitlement. They are based on the needs of the individual client as reflected in the plan of care.

(3) Medical Supplies.

(a) Medical supplies and appliances includes devices, controls, or appliances specified in the Plan of Care, not presently covered under the State Plan, which enable the individual to increase his/her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he/she lives. All waiver medical supplies and appliances must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Medical supplies and appliances do not include over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds will be in addition to any medical supplies furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the individual.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency.

(c) Medical supplies and appliances are limited to $6,000 per client per waiver year. Documentation of items purchased will be maintained by the targeted case manager. An additional amount above that of $6,000 may be requested by the client and approved by Medicaid if medically necessary.

(4) Assistive Technology.

(a) Assistive Technology includes devices, pieces of equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities as specified in the Plan of

Care. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisition, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds exclude items which are not of direct medical benefit to the recipient. Receipt of this service must be based upon medical necessity to prevent institutionalization as documented in the medical record and all items must meet applicable standards of manufacture, design and installation.

(b) The amount for this service is $20,000 per client. Any expenditure in excess of $20,000 must be approved by the Alabama Medicaid Agency. All assistive technology item must be ordered by a physician, documented on the Plan of Care and must be prior authorized and approved by the Alabama Medicaid Agency.

(c) To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents to the Alabama Medicaid Agency (AMA):

1. Medicaid Prior Authorization Form;

2. An agreement between the AMA and the company providing the service;

3. A price quotation list from the company supplying the equipment, providing a description of the item; and

4. A legible copy of the physician's prescription for the item.

(d) Upon completion of service delivery, the client or their legal representative must sign and date acknowledging satisfaction with the service.

(e) Providers of assistive technology shall be capable of supplying and training in the use of assistive technology devices.

Author: Luzenia Lawson, Associate Director, Long Term Care, Quality Review Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: **New Rule:** File May 12, 2003; effective June 16, 2003.
Amended: Filed August 11, 2008; effective September 15, 2008.
Amended: Filed June 11, 2014; effective July 16, 2014.

560-X-54-.04 Costs For Services.

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.
Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: New Rule: Filed May 12, 2003; effective June 16, 2003.

560-X-54-.05 Application Process.

(1) The targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community-based services.

(2) An assessment document will be completed by the targeted case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

(3) The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's plan of care, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency.

(5) Medicaid will review the medical application and determine if the individual meets the criteria for nursing facility care, in accordance with Rule No. 560-X- 10-.10 of the Alabama Medicaid Administrative Code and submit the “Waiver/Slot Confirmation Form” to the District Office for processing financial determination.

(a) If approved, the applicant and the targeted case manager will be notified in writing.

(b) If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14.

(6) When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

(7) A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be annually.
Author: Ginger Wettingfield, Director LTC Healthcare Reform Division
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: New Rule: Filed May 12, 2003; effective June 16, 2003. **Amended:** Filed August 11, 2008; effective September 15, 2008. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed June 11, 2018; effective July 26, 2018.

560-X-54-.06 Fair Hearings.

(1) An individual whose application to the Waiver Program is denied or waiver participants whose services are terminated, suspended, or reduced based on Rule No. 560-X-54-.02 may request an appeal in accordance with 42 CFR Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code, as modified by the below provisions.

(2) Home and Community-Based Services waiver participants will be given at least a ten-day notice before termination, suspension or reduction of services.

(3) If an individual/guardian chooses to appeal the decision, a written request for an informal conference must be received by the Operating Agency within 30 days from the effective date of the notice. Services may continue for waiver participants until the final outcome of the administrative appeal process, if the written request is received within 10 days after the effective date of the action.

(4) If the individual/guardian is dissatisfied with the Informal Conference decision, a Fair Hearing may be requested. A written request for a Fair Hearing must be received no later than 30 days from the date of the Informal Conference decision notice.

(5) If the individual/guardian is dissatisfied with the Fair Hearing decision, he/she may appeal pursuant to the provisions of the Alabama Administrative Procedure Act.

(6) The Operating Agency will take the lead role for the Informal Conferences, Fair Hearings and subsequent judicial appeals. Medicaid legal counsel and program staff will function as support staff.
Author: Luzenia Lawson, Associate Director, Long Term Care, Quality Review Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: New Rule: Filed May 12, 2003; effective June 16, 2003.
Amended: Filed August 11, 2008; effective September 15, 2008.
Amended: Filed June 11, 2014; effective July 16, 2014.

560-X-54-.07 Payment Methodology For Covered Services.

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) Payment will be based on the number of units of service reported on the claim for each procedure code.

(3) Accounting for actual cost and units of services provided during a waiver year must be captured CMS 372 Report. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

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

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

(c) The services provided by an operating agency are reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.
Author: Ginger Wettingfield, Director LTC Healthcare Reform Division
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.

History: New Rule: Filed May 12, 2003; effective June 16, 2003. **Amended:** Filed August 11, 2008; effective September 15, 2008. **Amended:** Filed June 11, 2014; effective July 16, 2014. **Amended:** Filed June 11, 2018; effective July 26, 2018.

560-X-54-.08 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 S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 C.F.R. Section 441, Subpart G.
History: New Rule: Filed May 12, 2003; effective June 16, 2003.

560-X-54-.09 Records.

(1) The Alabama Medicaid Agency shall maintain all information regarding claims submitted and paid for services provided eligible recipients. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log, service receipt, or some other record shall be used to show the date and nature of services; this record shall include the Recipient's signature or designated signature authority.

(3) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

(4) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The Alabama Medicaid Agency and Centers for Medicare and Medicaid Services and the operating agencies must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.
Author: Ginger Wettingfield, Director LTC Healthcare Reform Division
Statutory Authority: Section 1915(c), Social Security Act, 42 C.F.R. Section 441, Subpart G.

History: New Rule: Filed May 12, 2003; effective June 16, 2003.
Amended: Filed August 11, 2008; effective September 15, 2008.
Amended: Filed June 11, 2018; effective July 26, 2018.

560-X-54-.10 Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations and the Alabama 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 and criminal prosecution.
Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 C.F.R. Section 441, Subpart G.
History: New Rule: Filed May 12, 2003; effective June 16, 2003.

560-X-54-.11 Informing Individuals Of Choice.

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

(2) Residents of long-term care facilities for whom home- and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of review. 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: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 C.F.R. Section 441, Subpart G.
History: New Rule: Filed May 12, 2003; effective June 16, 2003.