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CHAPTER FIFTY-TWO

HOME AND COMMUNITY-BASED LIVING AT HOME (LH) WAIVER FOR THE MENTALLY RETARDED

Chapter 52 - Home and Community-Based Living at Home (LH) Waiver for the Mentally Retarded

Rule No. 560-X-52-.01. Authority and Purpose.

(1) Home and community-based services for the mentally retarded or related conditions 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 services, require the level of care available in an intermediate care facility (ICF/MR) for the mentally retarded. These services 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) Home and community-based services covered in this waiver are In-Home Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Occupational Therapy, Speech and Language Therapy, Physical Therapy, Behavior Therapy, Respite Care, Personal Care Services, Personal Care Transportation, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Skilled Nursing, Community Specialist Services, and Crisis Intervention. These services provide assistance necessary to ensure optimal functioning of the mentally retarded or persons with related conditions.

(3) The Home and Community Based Living at Home Waiver is administered through a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation and is restricted to individuals with a diagnosis of mental retardation or related condition, ages 3 and above, and those not residing in a group home situation. Priority access to the Living at Home Waiver shall be given to individuals on a verified waiting list.

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 September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.02. Description of Services.

Home and community-based services are defined as Title XIX Medicaid-funded services provided to mentally retarded individuals or persons with related conditions who, without these services, would require services in an ICF/MR. These services will provide health, social, and related support needed to ensure optimal functioning of the mentally retarded individual 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 service 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 waiver services. The specific services available as part of home and community-based services are:

(1) In-Home Residential Habilitation

(a) In-Home residential habilitation services provide care, supervision, and skills training in ADLs, home management and community integration.

(b) In-Home residential habilitation includes the following:

1. Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (i.e. moving a chair, substituting velcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

2. Habilitation supplies and equipment; and

3. Transportation costs to transport individuals to day programs, social events or community activities, when public transportation or transportation covered under the Medicaid state plan is not available, accessible or desirable due to the functional limitations of the client, will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

(c) Residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities.

(d) A unit of service is one hour. The place of service will primarily be the person's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

(e) In-Home residential habilitation goals must relate to identified, planned goals. Training and supervision of staff by a Qualified Mental Retardation Professional (QMRP) shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements must be met prior to the staff beginning work. Additional training to specifically address and further the goals in the individual's plan may occur on the job. Consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

(f) In-Home residential habilitation excludes the following:

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

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

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

4. Room and board costs.

(g) Providers of residential habilitation must be certified by the Department of Mental Health and Mental Retardation.

(2) Day Habilitation

(a) Day habilitation includes planning, training, coordination, and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

(b) The provider for Day Habilitation services can be reimbursed based on eight levels of services.

(c) Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client, will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health and Mental Retardation.

(3) Prevocational Services

(a) Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(b) When compensated, individuals are paid at less than 50 percent of the minimum wage.

(c) Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

(d) Providers of prevocational services must be certified by the Department of Mental Health and Mental Retardation.

(e) Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401[16] and [17]).

(4) Supported Employment

(a) Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(b) Supported employment is 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 individuals receiving waiver services, 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 furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

(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

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

(g) Transportation will be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual 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.

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

(5) Occupational Therapy

(a) Occupational therapy is 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 an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals 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 client’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 recipient and is necessary to enable the recipient to be cared for outside of an institution.

(c) Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed by the hour. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(d) Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered.

(6) Speech and Language Therapy

(a) Speech and language therapy 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 individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

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

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

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

(ii) Designing specialized programs for developing an individual's communication skills comprehension and expression.

(c) Therapists may also provide training to staff and caregivers (such as a client'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 recipient and is necessary to enable the 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 a physician. The need for service must be documented in the case record. Services shall be provided and billed by the hour. Speech and language therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered.

(7) Physical Therapy

(a) Physical therapy is physician-prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical therapy services include assisting in the evaluation of an individual to determine 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 client's family and/or foster family).

(c) 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.

(d) Documentation in the case record must justify the need for this service. Services must be listed on the care plan and be provided and billed by the hour. Physical therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered.

(8) Behavior Therapy

(a) Behavior Therapy Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for individuals 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. Behavior therapy may include consultation provided to families, other caretakers, and habilitation services providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

(b) A 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 Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

(d) The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

(e) Providers of 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 service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

(9) Respite Care

(a) Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care for a brief period of rest or relief for the family from day-to-day care giving.

(b) 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. In an instance of crisis relief, out-of-home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in their home, or if necessary, to locate another home for them.

(c) Some consumers are institutionalized because their community supports become exhausted, or because they are unsure of how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible.

(d) Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Mental Retardation, subject to review by the Alabama Medicaid Agency. The limitation on either in-home or out-of-home respite care shall be 1080 hours or 45 days per waiver participant per waiver year.

(e) Out-of-home respite care may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, out-of-home respite care may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out-of-home respite, no additional Medicaid reimbursement will be made for other services in the institution.

(f) Medicaid reimbursement shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

(10) 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 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 client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual.

(c) A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Mental Retardation and be subject to review by the Single State Agency for Medicaid.

(d) While in general, personal care will not be approved for a person living in a group home or other residential setting, the Division of Mental Retardation may approve it for specific purposes that are not duplicative.

(e) The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. 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 this service is 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 individual's documented need for the service 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 person is eligible for the 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 an hour of service, not including worker's time of travel to and from the place of work.

(h) Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor may they be legally obligated in any other way to provide the service. Any other 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 consumer's record by the provider agency.

(i) Effective October 1, 2006, personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. This service must be billed under a separate code to distinguish it from other personal care activities.

(11) Personal Care Transportation

(a) Personal care attendants may transport consumers 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 consumer 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 consumer as a result of being transported.

(b) 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 consumer.

(c) Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation 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.

(12) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations will provide physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization.

(b) Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but 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 client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

(c) The individual's home may be a house or an apartment that is owned, rented or leased. 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 adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.

(d) Total costs of environmental accessibility adaptations shall not exceed $5,000 per waiver year, per individual.

(13) Specialized Medical Equipment and Supplies

(a) Specialized medical equipment and supplies are devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

(b) This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable

and non-durable medical equipment and supplies not available under the Medicaid State plan.

(c) 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.

(d) All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per waiver year, per individual.

(14) Skilled Nursing

(a) Skilled nursing services are services listed in the plan of care 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 person'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.

(15) Community Specialist Services

(a) Community Specialist Services are professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not.

(b) The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

(c) Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

(d) The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver.

(e) The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory.

(f) The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client's needs and condition.

(g) A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

(h) This service is a cost effective and necessary alternative to placement in an ICF-MR. A unit of service is one hour.

(16) Crisis Intervention

(a) Crisis Intervention provides immediate therapeutic intervention, available to an individual 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 individual or of others and/or to result in the individual's removal from his current living arrangement.

(b) Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes 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) Crisis intervention will respond intensively to resolve crisis situations and prevent the dislocation of the person at risk such as individuals with mental retardation who are occasionally at risk of being moved from their residences to institutional settings because of family's inability to cope with short term, intense crisis situations. This service is a cost effective alternative to placement in an ICF-MR.

(d) Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

(e) Crisis intervention services require two levels of staff, professional and technician.

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

(g) When the need for this service arises, the service will be added to the plan of care for the person.

(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 DMH/MR prior to the service being initiated.

(j) Crisis intervention services will not count against the $25,000 per person per year cap in the waiver, since the need for the 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 consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;

6. Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and

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

Author: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
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Amended: Filed March 20, 2007; effective June 15, 2007. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.03. Eligibility.
Medical eligibility is limited to those individuals who meet the ICF/MR facility level of care. No waiver services 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 services will be available to the mentally retarded (MR) and persons with related conditions who would be eligible for institutional services under 42 CFR 435.217.

Financial eligibility is limited to the following individuals:

- Individuals receiving SSI.
- SSI related protected groups deemed to be eligible for SSI/Medicaid.
- Medicaid for Low Income Families (MLIF).
- Federal and State adoption subsidy individuals.

MR persons who meet categorical (including 42 CFR 435.120) medical and/or social requirements for Title XIX coverage will be eligible for home and community-based services under the 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: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
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Rule No. 560-X-52-.04. Characteristics of Persons Requiring ICF/MR Care.

(1) Generally, persons eligible for the level of care provided in an ICF/MR 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 intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/MR care is made by a Qualified Mental Retardation Professional (QMRP). A QMRP 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 QMRP and a physician.

(3) ICF/MR care includes those services that address the functional deficiencies of the beneficiaries and that require the skills of a QMRP 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: 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 September 20, 2002; effective December 26, 2002.

Rule No. 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 mental retardation or related 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 mental retardation or related 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 with the mentally retarded or related 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,
(i) Pharmacist,
(j) Doctor of Medicine,
(k) Psychiatrist, and
(l) Other skilled health professionals

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 September 20, 2002; effective December 26, 2002.

Rule No. 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 September 20, 2002; effective December 26, 2002.

Rule No. 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 "Individual Habilitation Plan" (IHP), 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 and Mental Retardation, which are based on eligibility criteria for ICF/MRs developed jointly by DMH/MR and the Alabama Medicaid Agency, will be utilized by the Department of Mental Health and Mental Retardation (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 and Mental Retardation, 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/MR, as described in Rule No. 560-X-35-.03. Re-evaluation of clients shall be performed on an annual basis. Written documentation of all assessments will be maintained in the client's case file and subject to review by the Alabama Medicaid Agency and Department of Health and Human Services.

(2) The Alabama Medicaid Agency will give notice of services available under the waiver as required by federal regulations, particularly to primary care givers for the target group, including but not limited to, programs operated by Alabama Department of Mental Health and Mental Retardation, the statewide network of community MH/MR centers, and to other appropriate care-giving agencies such as county Department of Human Resources offices, hospitals, hospital associations, and associations for the mentally retarded.

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 September 20, 2002; effective December 26, 2002.

Rule No. 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/MR 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: 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 September 20, 2002; effective December 26, 2002.

Rule No. 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 HCFA 372 Report.

Author: Patricia Harris, Administrator, LTC Program Management 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 September 20, 2002; effective December 26, 2002.
Amended: Filed August 20, 2004; effective November 16, 2004.

Rule No. 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 September 20, 2002; effective December 26, 2002.

Rule No. 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 September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.12. Records.
(1) The Department of Mental Health and Mental Retardation 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: 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 September 20, 2002; effective December 26, 2002.

Rule No. 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 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.

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 September 20, 2002; effective December 2002.

Rule No. 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 $25,000 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: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.
Amended: Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.15. Fair Hearings.

(1) An individual who is denied home and community-based services based on Rule No. 560-X-52-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(2) Recipients will be notified in writing at least ten days prior to termination of service.

(3) A written request for a hearing must be received by Medicaid within sixty (60) days following the date on the notice of action with which an individual is dissatisfied.

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 September 20, 2002; effective December 26, 2002.

Rule No. 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) Financial eligibility is limited to those individuals receiving SSI.

(3) The QMRP will complete the level of care determination and the plan of care development.

(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 applicant's physician must certify that "without waiver services the client is at risk of institutionalization."

(6) 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.

(7) The Alabama Department of Mental Health and Mental Retardation (ADMH/MR) 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.

(8) 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.

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

(10) Admissions and readmissions for clients who have not received services for the previous six (6) month period must be certified by a physician licensed to practice in Alabama.

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

(12) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a 10% 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.

(13) 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.

(14) 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/MR.

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

(16) 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.

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

(18) 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.

(19) 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.

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

(21) Once the individual's information has been added to the Long Term care File (RW), changes can only be made by authorized Medicaid staff.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed March 20, 2007; effective June 15, 2007.