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CHAPTER THIRTY-FIVE

HOME AND COMMUNITY-BASED WAIVER
FOR PERSONS WITH MENTAL RETARDATION

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Chapter 35. Home and Community-Based Waiver for Persons with Mental Retardation.

Rule No. 560-X-35-.01. Authority and Purpose.

(1) Home and community-based services for persons with mental retardation 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 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 Residential Habilitation Training, Residential Habilitation-Other Living Arrangement, Day Habilitation, Prevocational Services, Supported Employment, Occupational Therapy Services, Speech and Language Therapy, Physical Therapy, Behavior Therapy, Companion Services, Respite Care, Personal Care, Environmental Accessibility Adaptations, Medical Supplies, Skilled Nursing, Assistive Technology, Crisis Intervention, and Community Specialist. These services provide assistance necessary to ensure optimal functioning of the mentally retarded or persons with related conditions.

(3) The Home and Community Based Waiver is administered with a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation. Waiver services are limited to individuals with a diagnosis of mental retardation or related condition, age 3 and above.

Author: Laura Walcott, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987 and January 14, 1997. **Amended**: Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-35-.02. Description of Services.

Home and Community-Based Services (HCBS) 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 administering 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) Residential Habilitation Training

(a) Residential habilitation training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

(b) Staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming and cleanliness.

(c) This service includes social and adaptive skill building activities such as expressive therapy, the prescribed use of art, music, drama, and/or movement to modify ineffective learning patterns, and/or influence changes in behavior recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities.

(d) The cost to transport individuals to activities such as day programs, social events or community activities when public transportation and/or transportation services covered under the State Plan are not available, accessible or desirable due to the functional limitations of the recipient will be included in the rate paid to providers for this service.

(e) Residential Habilitation Training services may be delivered/supervised by a Qualified Mental Retardation Professional (QMRP) in accordance with the individual's plan of care.

(f) Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a Qualified Mental Retardation Professional.

(g) A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the Department of Mental Health/Mental Retardation. Retraining will be conducted as needed, at least annually.

(2) Residential Habilitation - Other Living Arrangement (OLA)

(a) Residential habilitation training in other living arrangements is a service in which recipients reside in integrated living arrangements such as their own apartments or homes. These services shall be delivered in the context of routine day-to-day living rather than in isolated "training programs" that dictate the individual transfers what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations with staff monitoring of clients served at periodic intervals. The basic concept of this service is that learning to be independent is best accomplished for some individuals by living independently.

(b) The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming and cleanliness.

(c) This service includes social and adaptive skill building activities such as expressive therapy, the prescribed use of art, music, drama, or movement to modify ineffective learning patterns, and/or influence changes in behavior, recreation/leisure

instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities.

(d) Residential habilitation training services for individuals in other living arrangements may be delivered/supervised by a QMRP in accordance with the individual's plan of care.

(e) Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

(f) A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the Department of Mental Health/Mental Retardation. Retraining will be conducted as needed, but at least annually.

(g) The cost to transport individuals to activities such as day programs, social events or community activities when public transportation and/or transportation services covered under the State Plan are 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.

(3) Day Habilitation

(a) Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

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

(c) Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care.

(d) Transportation cost associated with transporting 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 recipient 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.

(4) Prevocational Services

(a) Prevocational services are not available to recipients for eligible benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

1. Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job task oriented.

2. Prevocational services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

3. 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).

4. When compensated, individuals are paid at a rate of less than 50 percent of the minimum wage.

(5) 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.

1. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

2. Supported employment also includes activities needed to sustain paid employment by waiver clients, including supervision and training.

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

4. Supported employment may be provided under the Individual Job Coach and Job Development services to further encourage full integration of waiver participants into worksites where individuals without disabilities are employed.

5. Supported employment services are not available to 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.

6. 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.

(6) Occupational Therapy Services.

(a) Occupational therapy services include 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 function.

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

(c) Services must be prescribed by a physician and provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan, provided and billed in 15 minute increments. 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.

(7) Speech and Language Therapy

(a) Speech and language therapy services include screening and evaluation of individuals with speech and hearing impairments.

1. Comprehensive speech and language therapy is prescribed when indicated by screening results.

(b) This service provides treatment for individuals who require speech improvement and speech education. These are specialized programs designed for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

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

(8) Physical Therapy

(a) Physical therapy includes services which assist in the determination of an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

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

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

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

(9) Behavior Therapy

(a) Behavior therapy services provide~~s~~ 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~~s~~, 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 support plan may only be used after positive behavioral approaches have been tried, and its continued use must be reviewed and rejustified 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.

(10) Companion Services

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

1. The provision of 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 recipient.

3. This service is provided in accordance with a therapeutic goal in the plan of care and is not merely diversional in nature.

4. This service must be necessary to prevent institutionalization of the recipient.

(11) Respite Care

(a) Respite care is given to individuals unable to care for themselves on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

(b) Respite care may be provided up to a maximum of 1080 hours or 45 days per waiver year.

(c) This service cannot be provided by a family member.

(d) 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.

(e) 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.

(12) Personal Care

(a) Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene and activities

of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are essential to the health and welfare of the recipient. Personal care is not available to residents of a group home or other residential setting.

(b) 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 support the consumer's need to access the community and not merely to provide transportation. The Personal Care Transportation service will provide transportation in the community to shop, attend recreational and civic events, go to work, and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

(c) 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.

(d) 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 transportation where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

(e) 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.

(13) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations are those physical adaptations to the home, required by the recipients' 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.

1. 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 which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are also excluded from this Medicaid reimbursed benefit. All services shall be provided in accordance with applicable State or local building codes.

(14) Medical Supplies

(a) Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

(b) These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacturer, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Mental Health and Mental Retardation. Medical supplies are limited to a maximum of $1,800.00 per recipient per year. The operating agency (OA) must maintain documentation of items purchased for the recipient.

(15) Skilled Nursing

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

(16) Specialized Medical Equipment

(a) Specialized medical equipment includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, and equipment necessary for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefits to the recipient. Invoices for medical equipment must be maintained in the case record. This service must be necessary to prevent institutionalization of the recipient. All items shall meet applicable standards of manufacturer, design and installation. Costs are limited to $5,000 per recipient, per year.

(17) Community Specialist Services

(a) Community Specialist Services include 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 term 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 visit the consumer every 180 days and call at 90-day intervals to ensure services are being delivered and satisfactory.

(f) The community specialist will communicate with the case manager quarterly 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 15 minutes.

(18) 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 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 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 recipient 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 situations; 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 caregiver, death of loved one, etc.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended:** November 18, 1987 and January 14, 1997. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed November 19, 2007; effective February 15, 2008. **Amended:** Filed January 21, 2009; effective April 17, 2009.

Rule No. 560-X-35-.03. Eligibility.

Eligibility criteria for home and community-based services recipients shall be the same as eligibility criteria for an ICF/MR. Thus services will be available to Persons with Mental Retardation who would be eligible for institutional services under 42 CFR 435.217 and who are now eligible under 435.120. Mentally Retarded 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.

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

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

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

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987. Effective date of this Amendment January 14, 1997. **Amended**: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** March 21, 2005; effective June 16, 2005. **Amended:** Filed January 20, 2010; effective April 16, 2010.

Rule No. 560-X-35-.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 483.430. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a 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: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended:** November 18, 1987. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-35-.05. Qualifications of Staff Who Will Serve As Review Team for Medical Assistance.

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

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

(3) The psychologist shall be a PH.D. in Psychology. This person shall be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two (2) years' experience.

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

(a) Special Education
(b) Speech Pathologist
(c) Audiologist
(d) Physical Therapist
(e) Optometrist
(f) Occupational Therapist

(g) Vocational Therapist
(h) Recreational Specialist
(i) Pharmacist
(j) Doctor of Medicine
(k) Psychiatrist
(l) Other skilled health professionals

Authority: 42 C.F.R. Section 441, Subpart G, and the Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.06. Financial Accountability.

(1) 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 the travel cost of the auditors to the location of the records.

(2) The MR Waiver has transitioned from a cost-based reimbursement system to a fee-for-service payment system. In order to ensure that the payments in a fee-for-service system are proper, the providers will be required to maintain cost report data and to submit Medicaid cost reports for three cost report periods. The cost report periods are: October 1, 2004 through December 31, 2004; January 1, 2005 through September 30, 2005; October 1, 2005 through September 30, 2006. Cost reports are due to Medicaid no later than ninety (90) days after the ending date of the reports as indicated above. Extension may be granted only upon written request. If a complete cost report is not filed by the due date or an extension is not granted, a penalty of $100 per day for each day past the due date will be imposed on the provider. The penalty will not be a reimbursable Medicaid cost. For detailed information on penalties see MR Waiver Fiscal Procedures Manual.

(3) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, “Cost Principles for state and local government" will apply to governmental agencies participating in this program. For non-governmental agencies, OMB Circular, A-110 (Uniform administrative requirements for grants and other agreements with Institutions of Higher Education, hospitals and other non-profit organizations) and generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(4) Cost Allowable and Unallowable

(a) 45 C.F.R., part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies. For governmental agencies, all reported costs will be adjusted to actual costs at the end of the fiscal year.

(c) Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for residential habilitation training, day habilitation training, prevocational services, supported employment, occupational therapy, speech therapy, physical therapy, individual family support services, behavior management, companion services, respite care, personal care, environmental modifications, specialized medical equipment and supplies, assistive technology, personal emergency response system, and skilled nursing are recognized expenses.

(d) Allowable costs are defined in OMB Circular A-122 (cost principles for non-profit organization) or OMB Circular A-87. Detailed descriptions of allowable costs and restrictions on those costs are found in the MR Waiver Fiscal Procedures Manual.

(e) Unallowable costs are specified in OMB Circular A-87 or Circular A-122. In addition to these, the following are not covered by this program:

1. Costs covered by other programs, such as:
   - (i) Prescription drug
   - (ii) Dental expenses
   - (iii) Ambulance
   - (iv) Physician's fees
   - (v) Lab expenses for clients
   - (vi) Oxygen
   - (vii) Inhalation therapy
   - (viii) Group therapy
2. The cost of advisory council consultants without Alabama Medicaid Agency's approval.
3. Legal fees as follows:
   - (i) Retainers
   - (ii) Relating to fair hearings
   - (iii) In connection with law suits that result in an adverse decision for the provider
   - (iv) Services that duplicate functions performed by Medicaid or the providers, such as eligibility determination for the program,
   - (v) Other legal fees not relating to the provision of services to the beneficiaries
4. Dues and subscriptions not related to services authorized under the waiver.
5. Detailed description of unallowable costs is specified in the MR Waiver Policy and Procedures Manual.

(5) Cost Allocation Plans

(a) State agencies are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 C.F.R. 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project with a fund, there must be a written plan to distribute costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service. This cost can be prorated to each service by a method described in writing. This first type of cost qualifies for the federal match benefit percentage. The second type of cost is reimbursed at the administrative federal financial participation rate. See rule 560-X-35.09 (8) for definition.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. At a minimum, these contracts should meet the requirements of 45 C.F.R. 95.507; these contracts must indicate:

1. The specific services being purchased
2. The basis upon which the billing will be made (e.g., time reports, number of homes inspected, etc.).

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR, Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987, November 10, 1988, and May 15, 1990. Effective date of this Amendment January 14, 1997.
Amended: Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed January 21, 2009; effective April 17, 2009.

Rule No. 560-X-35-.07. Individual Assessments.

(1) Alabama Medicaid Agency will require an individual plan of care for each waivered 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. 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 waivered 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.

Authority: 42 C.F.R. Section 441, Subpart G and the Home-and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.08. Informing Beneficiaries of Choice.

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

(2) Residents of long-term care facilities for whom home- and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of review. Applicants for SNF, ICF, ICF/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 for 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.

Authority: 42 C.F.R. Section 441, Subpart G and the Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Amended November 18, 1987. Effective date of this amendment May 15, 1990.

Rule No. 560-X-35-.09. Payment Methodology for Covered Services.

(1) The Medicaid reimbursement for each service provided by a mental health service provider shall be based on a fee-for-service system. Each year’s rate will be trended forward by using the prior year’s rate adjusted by the medical portion of the consumer price index. The new rate will be reported to the Alabama Medicaid Agency fiscal agent liaison to be input into the system.

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

(3) The basis for the fees will be the past rate history and amount of care needed based on acuity of client disability with consideration being given to the medical care portion of the consumer price index.

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

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on HCFA's form 372.

Author: Laura Walcott, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987, May 15, 1990, and January 14, 1997. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed October 21, 2004; effective January 14, 2005.

Rule No. 560-X-35-.10. Third Party Liability.

Providers shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments and benefits prior to applying for Medicaid payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR, Section 433, Subpart D – Third Party Liability.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.11. Payment Acceptance.

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

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

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 447, Subpart A – Payments: General Provisions.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.12. Confidentiality.

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

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 431.306, Subpart F – Safeguarding Information on Applicants and Recipients.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.13. 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) Sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 431.107, Subpart C – Administrative Requirements: Provider Relations.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.14. Service Providers.

The Home and Community-Based MR Waiver is a cooperative effort between the Alabama Medicaid Agency and the Department of Mental Health and Mental Retardation.

Author: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: The Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective January 14, 1997. **Amended:** Filed October 21, 2004; effective January 14, 2005.

Rule No. 560-X-35-.15. Application Process.

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

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

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

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

(5) The Qualified Mental Retardation Professional (QMRP) will complete the level of care determination and the plan of care development.

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

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

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

(9) 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 Home and Community-Based Waiver for Persons with Mental Retardation.

(10) 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.

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

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

(13) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Home and Community Based Waiver for Persons with Mental Retardation 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 random sample of plans of care and related documents annually.

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

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

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

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

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

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

(20) Neither the Alabama Medicaid Agency nor EDS will send out the LTC-2 Notification letters. The record of successful transmission will be your record of "approval" to begin rendering service.

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

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

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective January 14, 1997. **Amended**: Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed November 19, 2007; effective February 15, 2008.

Rule No. 560-X-35-.16. 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 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.

Authority: 42 C.F.R. Section 441, Subpart G and the MR/DD Waiver. Rule effective January 14, 1997.

Rule No. 560-X-35-.17. Fair Hearings.

(1) An individual who is denied Home and Community-Based Services based on Rule No. 560-X-35-.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 filed within sixty days following notice of action with which an individual is dissatisfied.

Authority: 42 C.F.R. Section 431, Subpart E. Rule effective January 14, 1997.

Rule No. 560-X-35-.18. Reserved.