

**ALABAMA MEDICAID AGENCY POLICY AND PROCEDURE MANUAL**  
**HOME AND COMMUNITY BASED SERVICES**  
**TECHNOLOGY ASSISTED WAIVER**

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# CHAPTER 1

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## PROGRAM ADMINISTRATION

The Alabama Medicaid Agency (AMA) with the oversight of The Centers for Medicare and Medicaid Services (CMS) is responsible for administration of the home and community-based service (HCBS) waivers.

### A. CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. CMS is a federal agency within the Department of Health and Human Services that is responsible for the oversight of administering Medicaid and Medicare programs. The central office is located in Baltimore Maryland, and the states are divided into regions. The state of Alabama is located in Region IV.
2. Any new waiver requests are submitted to the central and regional offices for approval. If an HCBS waiver requires an amendment to its originally approved contents, submission is sent to the regional office for approval. A contact person for the home and community based waivers is assigned in each region. CMS staff is responsible for making sure the waiver is implemented and administered according to the waiver document and all assurances are being met. The HCFA 372 report is submitted on an annual basis and is used to determine whether or not the program is meeting the client's health care needs and whether a client's health and safety is being safeguarded. CMS also conducts compliance reviews. The review schedule and activities are coordinated with the AMA Long Term Care (LTC) Division. During the review, the representatives interview waiver participants, providers and State Medicaid staff who perform duties applicable to the operation and monitoring of the waiver. These are usually done during the year prior to the expiration of the waiver.

### B. ALABAMA MEDICAID PROGRAM

1. Medicaid was created in 1965 by congress along with a sound-alike sister program,

Medicare. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. Medicaid started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state Agency. In 1981, it was renamed the AMA.

2. The AMA administers the state Medicaid Program as directed by the governor. The head of the agency is the Commissioner, who serves at the pleasure of the Governor. Medicaid also serves as the administering agency in the waiver programs. The LTC Division, under Program Administration, in collaborative effort with other state agencies, is responsible for administrative oversight of the waiver. A list of contact numbers in the LTC Division can be found in the Contact Us Section on the Medicaid Website, [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)
3. A description of the State Plan services offered through the AMA can be found in the Providers Section under Fee Schedules on the Medicaid Website, [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

### C. FISCAL AGENT

1. The AMA contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Title XIX State plan. The current fiscal agent is Hewlett Packard (HP) (former known as Electronic Data System (EDS)).

2. HP is responsible for enrolling providers in the Medicaid program and for maintaining provider information in the Alabama Medicaid Management Information System (AMMIS). They are also responsible for preparing and distributing provider billing manuals to providers of Medicaid Services for guidance in filing and preparing claims. The fiscal agent's Provider Inquiry Unit, through provider representatives is available for technical assistance and education to Medicaid providers of service. Providers with questions about claims should contact them directly for assistance. Please see the Medicaid\_Website, [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov), for contact information and for the Provider Electronic Solution (PES) information.

## CHAPTER 2

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### HOME AND COMMUNITY-BASED WAIVERS

Home and Community Based Services (HCBS) is one of the most popular Medicaid options available to states. Authority to grant waivers was provided by section 2176 of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act. Under Section 1915(c) of the Social Security Act, the Centers for Medicare and Medicaid Services waived certain statutory requirements to allow a State to cover a broad array of HCBS as an alternative to institutionalization. In other words, the Waiver “waives” existing rules of the Social Security Act. It is beneficial as it allows the client to receive services in the home. It gives the client a choice between institutional care and waiver services. The waivers must define a distinct population, define a level of care, and be cost-effective to prevent institutionalization or encourage out placement. Under this statutory authority, waivers are granted for an initial term of three years. Upon the state’s request, the waiver may be renewed for an additional five-year period.

The State develops the waiver proposal and submits it to CMS for approval. The state of Alabama developed six HCBS waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this State. HCBS programs serve the elderly and disabled, intellectual disabled, and disabled adults with specific medical diagnoses. These programs provide quality and cost-effective services to individuals at risk of institutional care.

Alabama’s HCBS Waivers are the Elderly and Disabled Waiver (EDW), Intellectual Disabilities Waiver (IDW), State of Alabama Independent Living Waiver (SAIL), Living at Home Waiver (LHW), HIV/AIDS Waiver, and the Technology Assisted Waiver for Adults (TAW). The information in this manual will be specific to the TAW for Adults

#### A. TA WAIVER FOR ADULTS

1. The TAW for Adults Program provides home and community-based services to individuals, age 21 and over with complex skilled medical conditions, who are ventilator-dependent or who have a tracheostomy and live in the community who

would otherwise require nursing facility care. The TAW for Adults was initially approved by the CMS effective February 22, 2003. The waiver is granted under provisions of Section 1915(c) of the Social Security Act. The current waiver was approved for a five-year period that began February 22, 2011 – February 21, 2016.

2. The Alabama Department of Rehabilitation Services (ADRS) serves as the operating agency (OA) for the waiver and is responsible for the day-to-day operations of the program. This includes managing the program by focusing on improving care for the client, protecting the health and welfare of the client, giving the client free choice of providers and waiver service workers, and making sure all direct service providers meet the qualifications as outlined in the waiver document.
3. The AMA's Fiscal Agent assigns the OA provider numbers. The provider numbers are used to identify the OA and for claims processing. **The provider number assigned to the HIV/AIDS Program is 1255474458.**
4. The operating agencies and the provider of direct services shall furnish any recipient, program or provider information to the AMA upon request.
5. To participate in the TAW for Adults program, direct services providers must meet all provider qualifications, licensure, and certification requirements as outlined in this manual and the TAW document.

## B. WAIVER REQUIREMENTS

The waiver defines the target population and the related eligibility criteria; gives assurances regarding program operation; lists the services to be provided, including the definitions of those services, provider qualifications, and anticipated utilization; estimates the numbers to be served and the related costs; compares waiver costs to institutional costs to demonstrate cost-effectiveness; and gives other information about program administration. The waiver may be amended with the approval of CMS.

## C. ASSURANCES

In order to receive waiver approval and comply with Federal Regulations that cover waivers, the AMA must make the following assurances to CMS for every HCBS waiver that is approved and implemented. Violation of these assurances could result in the termination of the waiver.

The AMA provides the following assurance to CMS:

1. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
  - (a) Adequate standards for all types of providers that furnish services under the waiver;
  - (b) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
  - (c) Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which HCBS will be provided, are in compliance with applicable State standards and meet the requirements of 45 CFR Part 1397 for board and care facilities.
2. The Agency will provide for an evaluation and periodic reevaluations at least annually of the continuing need for the level of care.

3. When an individual is determined to be likely to require nursing facility level of care and is included in the targeting criteria, the individual or his or her legal representative will be:
  - (a) Informed of any feasible alternatives under the waiver; and
  - (b) Given the choice of either institutional or HCBS.
4. The Agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of HCBS as an alternative to institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.
5. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in of the waiver document of this request under the State Plan that would have been made in that fiscal year had the waiver not been granted.
6. The Agency's actual total expenditures for HCBS and other Medicaid services under the waiver and its claim for Federal Financial Participation (FFP) in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s).
7. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid funded institutional care that they require.
8. The Agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State Plan and on the health and welfare of the persons served on the

waiver. The information will be consistent with a data collection plan designed by CMS.

9. The Agency will assure financial accountability for funds expended for HCBS, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
  
10. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver through monitoring of the quality control procedures described in the waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure that the quality of services furnished under the waiver and the State Plan will be provided to waiver clients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner consistent with the severity and nature of the deficiencies.

#### D. TARGETED POPULATION

The TA Waiver will be available to eligible clients in the community who meet the current institutional nursing facility admission criteria and who:

1. Are at the point of discharge from a general acute care facility, and without the availability of waiver services would be eligible for placement in a nursing facility.
  
2. Reside in the community, but are in danger of institutionalization, when their disabilities and level of functioning are such that, without the

availability of waiver services nursing facility placement would probably occur.

3. Are residents of a nursing facility, and who opt to leave that facility because of available HCBS.

## E. SERVICES

The services approved in the waiver are listed below. Please refer to Chapter 7 for service definitions.

- |    |                                    |          |
|----|------------------------------------|----------|
| 1. | Case Management**                  | T1016-UB |
| 2. | Personal Care / Attendant Services | T1019-U5 |
| 3. | Medical Supplies                   | T2028-U5 |
| 4. | Private Duty Nursing - RN          | S9123-U5 |
| 5. | Private Duty Nursing - LPN         | S9124-U5 |
| 6. | Assistive Technology               | T2029-U5 |

\*\*Targeted Case Management which includes transitional services.

(A covered service under Medicaid's State Plan)

## CHAPTER 3

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### ELIGIBILITY

The Alabama Medicaid Program is a medical assistance program that is jointly funded by the federal government and the state of Alabama to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility.

#### A. DETERMINATION PROCESS

1. Medicaid eligibility is determined by policies established by and through the following agencies:
  - a. Social Security Administration (SSA)
  - b. Alabama Medicaid Agency (AMA)
  - c. Department of Human Resources (DHR) (SUP and Federal/State Adoption Subsidies)
2. Names of eligible individuals and pertinent information are forwarded to Medicaid who, in turn, makes the information available to HP. Any questions concerning general or specific cases should be directed in writing to Medicaid or the appropriate certifying agency.
3. Current eligibility for the Alabama Medicaid Program must be verified or established before admission to the TA Waiver for Adults Program. Medicaid eligibility for Supplemental Security Income (SSI) clients is established by the SSA.

4. Medical eligibility is determined based on current admission criteria for nursing home care as described in Chapter 10 of the Alabama Medicaid Administrative Code.
  - a. Potential waiver clients must be “at risk” of nursing home placement.

An individual may be at risk of nursing home placement when:

- The individual is deficient in one or more of the following areas: functional, health, cognitive/emotional, informal support; to the extent that it consistently places the client’s health and/or safety in jeopardy of an adverse outcome.
  - The degree of dependency on primary caregivers or direct care provider of personal care increases particularly when combined with multiple medical problems, episodes of confusion, inappropriate behavior, and/or incontinence
- b. If a waiver client appears to be medically ineligible, additional medical information must be obtained from the physician or physician’s staff if the physician is unavailable.
  - c. Every effort should be made by the Case Manager (CM) to discuss the medical information with the physician. The CM can contact the physician’s staff if he or she is unable to communicate with the physician. The CM should consult with the state office on difficult cases that cannot be resolved in the county office or on cases where efforts to verify medical information from the physician have been unsuccessful.
  - d. Special efforts should be made to discuss the level of care decision and possible alternatives with the client, responsible party, and/or significant other. The client must receive a 10-day notice prior to terminating the case. The client is notified of this determination and the date of the termination must be indicated in the letter. The client can continue to

receive services through the date of termination. All appeals procedures should be explained clearly to the client.

- e. All recipients applying for the TA Waiver for Adults program who are under the age of 65 and have not been determined disabled will be required to have disability determined by Medicaid before processing the financial determination.
5. The Medicaid District Office determines financial eligibility for the other groups served through the TA Waiver for Adults program.
- a. Certain protected groups deemed to be receiving SSI are:
    - (1) Continuous - Those individuals who are not eligible for SSI because their income exceeds the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977 ("Pickle People") (42 CFR 435.135).
    - (2) Disabled Widow/Widower - A widow/widower between the ages of 50 and 59 who would be eligible for SSI except for entitlement to Social Security resulting from a change in the definition of disability and who is not eligible for Part A Medicare (P.L. 99-27251202 and P.L. 100-203, S 9108).
    - (3) Disabled Widow/Widower - A widow/widower between the ages of 60 and 65 who lost SSI as a result of receiving Social Security and who is not receiving Medicare (P.L. 100-203, S9116).
    - (4) Disabled Adult Child - An individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child (P.L. 99-643).

(5) Medicaid Low Income Families (MLIF) – An individual who is receiving aid to families with dependent children (42 CFR 435.110).

(6) State Supplementation – An individual who is not eligible for SSI or optional State Supplements because of requirements that do not apply under Title XIX of the Act (42 CFR 435.122).

b. The special home and community-based waiver group at 42 CFR 435.217 includes individuals who are eligible under the Medicaid State Plan if institutionalized.

6. DHR determines financial eligibility for the following groups served through the TA Waiver for Adults program:

a. SUP – Individuals who are ineligible for SSI or optional State Supplements because of requirements that do not apply under title XIX of the act. (42 CFR 435.122)

b. State Adoption Subsidy Individuals – Individuals under age 21 who are under State adoption assistance agreements. (42 CFR 435.227)

c. Federal Adoption Subsidy Individuals – Children for whom adoption assistance or foster care maintenance payments are made. (42 CFR 435.145)

**\*\*Please note: State or Federal adoption subsidized individuals must have a disability determination on file to be eligible for the TA Waiver for Adults Waiver.**

7. Financial Ineligibility

- a. If at any point a waiver client becomes financially ineligible, all services must be terminated and the case must be closed effective the date of financial ineligibility.
- b. Evidence of financial ineligibility must be documented. Methods of verification include:
  - (1) MSIQ screen,
  - (2) Letter or documentation from SSA,
  - (3) Written verification from the Medicaid District Offices.
- c. The CM must verify a client's Medicaid ineligibility before the client is terminated from the waiver.
- d. Special efforts must be made to contact and discuss possible alternatives with the client, responsible party, and/or significant other if the client requires services in the community. Referrals should be made on behalf of the client to other community agencies.
  - A waiver client who loses financial eligibility for Medicaid for up to 100 days due to excess resources, lump sum payment, etc., who is still within the active redetermination period, can immediately be reentered into the waiver after financial eligibility has been reestablished and verified. The case should be handled as follows:
    - The LTC segment will remain open;
    - A copy of the Slot Confirmation Form (Form 376) will be forwarded to the Medicaid TA Waiver for Adults Program Manager for QA audit purposes;

- In cases where a Form 376 is not used, the client's name and Medicaid number will be forwarded to the Medicaid TA Waiver for Adults Program Manager for QA audit purposes;
- Prior to restoring service the client must indicate their choice of community care vs. institutional care;
- The CM must conduct a face to face visit with the client in the home;
- The CM will complete a reassessment of the client's needs;
- A review of the Care Plan must be completed; and
- An initial visit with the DSP and CM must be completed.

If an audit by the Waiver QA Unit reveals that the above listed requirements were not met during the process of reestablishing eligibility, then a recoupment will be initiated. If the time period of financial ineligibility exceeds 100 days then the application must be processed as a readmission. During the client's period of financial ineligibility, the OA can continue services at their discretion.

8. To receive services under the TA Waiver for Adults program an individual must meet one of the following Medicaid eligibility criteria:
  - a. SSI
  - b. SSI recipients (Protected groups deemed to be SSI recipients)
  - c. Institutional Deeming Category

- The institutional deeming process may be used to disregard a potential waiver recipient's parental or spousal income in the community, which may be too high thereby making the individual ineligible to receive waiver services.
- Individuals using the institutional deeming process or 300% of SSI criteria will have to complete the Form 204/205. This is a financial eligibility determination form which is reviewed and processed by the Medicaid District Office, Eligibility Division. Form 376 (Waiver Slot Confirmation Form) should also be submitted at this time.

Note: only original copies of the Form 204/205 will be accepted. Xerox copies will not be accepted by the AMA.

- (1) The clients in the target groups for TA Waiver for Adults services must meet the nursing facility Level of Care.
- (2) The final level of care determination will be made by Registered Nurses at the OA in accordance with Chapter 10 (36) of the Alabama Medicaid Administrative Code. The AMA Waiver Quality Assurance Division will do a random retrospective review of TA Waiver for Adults clients to ensure that documentation supports the medical level of care criteria, appropriate physician certification is documented, as well as other state and federal requirements.

9. The TA WAIVER FOR ADULTS will be available to eligible clients in the community based upon current institutional nursing facility admission criteria who:
  - a. Are at the point of discharge from a general acute care facility, and except for the availability of waiver services, the client would be eligible for placement in a nursing facility.

- b. Reside in the community, but are in danger of institutionalization, when their disabilities and level of functioning are such that, without the availability of waiver services nursing facility placement would probably occur.
  - c. Are residents of a nursing facility, and who opt to leave that facility because of available HCBS.
10. TA WAIVER FOR ADULTS services cannot be delivered to persons who:
- a. Reside in a domiciliary or assisted living facility,
  - b. Reside in a nursing facility,
  - c. Receive services through any other approved and implemented HCBS waiver program,
  - d. Have a primary diagnosis of mental illness and/or **mental retardation**,
  - e. Are not approved for the services indicated on the Plan of Care,
  - f. Choose nursing facility care,
  - g. Move to another state,
  - h. Refuse to sign the HCBS-1 form,
  - i. Whose health and safety is at risk in the community as determined by the AMA and/or the OA,

- j. Are uncooperative with a provider in the provision of services,
- k. Have Medicaid eligibility blocked due to transfer of assets,
- l. Are in a hospital or other acute care facility,
- m. Are in a hospital PHEC bed or swing bed,
- n. Reside in a ICF/MR facility,
- o. Receive Hospice services paid for by Medicaid,
- p. Reside in a boarding home. (Except case management and services that may be provided outside the home, such as Adult Day Health.),
- q. Are unable to provide a healthy and safe environment in which waiver services can be delivered., and
- r. Are unable to sustain an environment in which providers are treated with dignity and respect.

11. Number of individuals to be served

Each waiver program is allotted a certain number of “slots” to be filled by clients approved to receive waiver services within a waiver year. If a client transfers from one waiver to another, goes into a nursing facility, loses waiver eligibility, or expires (dies) within the same waiver year, this slot is considered filled and therefore may not be refilled by a different individual. This filled slot should remain vacant unless the same client who had previously left the slot is refilling it. Placing a waiver client in a filled slot in any of the cases above would count as two unduplicated slots. An approved waiver participant should therefore be placed in one of the remaining available slots. Waiver slots may not be refilled until the beginning of the new waiver year.

12. Age criteria

The age criterion for admission to the TA Waiver for Adults program is age 21 and over.

B. Verification of Medicaid Eligibility

1. Eligibility must be verified at least monthly since it will no longer be indicated on the card. Several options are available for accessing this information. Providers may choose the option that works best for them
2. If there is incorrect information on the plastic card, the recipients should report the changes to the agency that certified him or her for Medicaid. When the certifying agency corrects the information, a new plastic card will automatically be sent to the recipient. In Alabama, the agencies that certify individuals for Medicaid are the SSA, DHR, and the AMA.
3. If a recipient loses the plastic card issued to him or her, they should call the Medicaid Recipient Inquiry Unit at 1-800-362-1504 and ask for a replacement card.
4. Claims submitted for services furnished must contain all thirteen (13) digits of the recipient's Medicaid number.

## CHAPTER 4

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### ADMISSION AND APPLICATION PROCESS

The AMA develops criteria for admission to all home and community based waiver programs. The AMA provides training for OAs' case management staff and nurse consultants upon request. Through these collaborative efforts, applicants are screened for appropriateness of admission to the program, care plans are developed based on individualized needs, the medical level of care determinations are assessed, and recipients are linked to providers for service delivery.

#### A. WHERE TO APPLY

Applicants may apply through either of the OA of the TA Waiver for Adults program by contacting any County Public Health Department in or near the county close to where the applicant resides. The OA may also receive referrals from family members, interested neighbors or friends, physicians, hospitals, nursing homes, or staff of a public or private agency.

#### B. Intake Screening

Prior to assessment for the waiver program, the case management staff for the TA Waiver for Adults program screens the applicant for their desire for waiver participation and their likelihood to meet financial and level of care eligibility criteria. These activities are preliminary requirements for waiver enrollment and are distinct from case management activities but are included in this scope of service and are recorded as administrative activities. These activities are documented in the case record.

1. The intake and screening process is involved and must include documentation regarding the following:
  - a. The applicant has been informed about the application process;
  - b. The applicant has been informed of all direct service providers and allowed his or her freedom of choice of providers;
  - c. The applicant has been informed of all HCBS programs of which he or she may benefit and allowed freedom of choice of programs; and

- d. The applicant has been informed of choice options regarding case management services.
- e. The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the client is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The reason for the absence of a signed choice should be well documented in the case record. Signatures with the mark of an X are accepted followed by a statement “Mark of recipient’s name” and the mark must be witnessed. If the applicant is physically impaired to the extent that he or she is unable to sign for him or herself, the legal representative may sign the form as follows: “Jack Jones signed by Joe Scott.” It must be clearly documented why the applicant did not sign.
- f. Documentation should also include:
  - (1) The setting and the persons present and the involvement of the applicant and or significant other during the assessment process;
  - (2) The support systems (formal and informal) that the applicant currently receives;
  - (3) The service needs;
  - (4) Emergency backup plan for those applicants who are considered “at risk” if visits are not made. (A disaster preparedness plan should also be in place.); and
  - (5) The CM documentation that he or she has discussed the client’s rights and responsibilities with the client, responsible party, and/or significant other.

## C. APPLICATION PROCESS

The Home and Community-Based Services Program Assessment (HCBS-1) is the required application developed by the AMA for support of the assessment, risk of institutionalization, and plan of care.

- 1. The CM with the aid of the applicant’s physician must complete the HCBS-1 application on all individuals that have been determined appropriate for admission to the program.

2. The CM is responsible for obtaining the most reliable and accurate information available. The applicant's diagnoses and medications should be indicated on the HCBS-1 application.
3. The signature of the applicant should be present to ensure that the applicant has been involved in the care plan development and given the OA permission to share information with involved providers.
4. The physician's signature should be present to indicate that the applicant is at risk for institutional care and that HCBS will prevent or delay the need for institutional care.
5. The plan of care must include the name of the provider of services, objectives, services, frequency of services, and the start and end dates for the services. Any changes to the plan of care must be documented.
6. The HCBS-1 application must be submitted to the OA nurse consultant by the CM upon completion by the physician. The OA nurse consultant will review the application to obtain a clear picture of the client's medical status and functional abilities, psychosocial behavioral status, and home environment.
7. If the information is complete and supports the above and the criteria developed by the AMA, the OA nurse consultant will approve the application. **The application will be processed through the HP system.** The application will have up-front edits performed. If there are no problems identified, the system will produce a LTC segment and an acceptance will be returned to the OA. The LTC segment validates approval for dates of service delivery. If the upfront edits performed identify problems, then a rejection notice will be returned to the OA with reasons for rejection. **Corrections must be made and the information resubmitted to the HP system.**
8. The CM will be informed of the approval when received. The CM will in turn provide a service authorization to the provider chosen by the recipient for the initiation of service delivery.
9. If the information on the application is not complete, the OA nurse consultant will return the application to the CM for additional information.

#### D. DENIALS BY OPERATING AGENCIES

The OA may deny an application which may include, but are not limited to the following circumstances:

1. There is no physician certification.

2. A new admission application with less than two (2) medical criteria checked on the application.
3. A request for additional necessary medical information to process the application is not received within 60 days.
4. The OA cannot safely maintain the individual in the community.
5. The waiver does not cover the eligibility group.

A letter indicating the reason for denial must be mailed to the recipient by the OA including procedures for requesting an informal conference and/or a fair hearing. If the recipient is still dissatisfied with the decision after the informal conference, they may request a fair hearing.

#### E. REDETERMINATIONS

Redeterminations of the TA Waiver for Adults clients must be performed on an annual basis.

1. The CM must complete a new HCBS-1 application in the month that the current determination expires. The redetermination should be the same process as for the initial assessment process.
2. In an effort to balance caseloads of CMs, a redetermination may be submitted early for approval.
3. **The HP system will not accept applications more than 45 days prior to the redetermination date unless it is marked as an early redetermination.**

#### F. RETROSPECTIVE REVIEWS

**The AMA nurse reviewers will perform a random review of all applications that are accepted into the HP system.** For a more detailed description of retrospective reviews, please refer to the Quality Assurance section of this manual, Chapter 9.

## CHAPTER 5

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### RECIPIENT UPDATE AND REVIEW

#### A. READMISSION

If a client has received home and community-based waiver services in the [HIV/AIDS](#) Program in the state of Alabama, but has been terminated and is reapplying during the same year, the admission requirements will be equivalent to those of a new admission.

#### B. TRANSFERS

1. When a client transfers from one county to another within the state within the same OA no information should be submitted to Medicaid until the redetermination is due.
2. When transferring from one OA to another, the original OA should:
  - a. Send a copy of the HCBS-1 application to the receiving OA
  - b. Attach a cover letter to include any pertinent information about the client the receiving OA may need.
3. When transferring from one OA of services to another, the receiving OA should:
  - a. Submit to the OA nurse consultant the HCBS-1 application which should include a new assessment on page 1, 2, and a new care plan on page 4, and a copy of the medical form that was previously in place.

- b. The receiving CM should verify that there is continued medical and financial eligibility effective on the transfer date.
- c. The comments section on page 2 of the HCBS-1 application should contain information about the transfer. For example, this recipient transferred to this provider from ADPH on 8/1/01. This replaces the old instructions of writing transfer in the upper left corner of the form above the client's name.
- d. The receiving agency must agree to accept the transfer in advance. The CM should coordinate the transfer to end on the last day of one month and start with the new OA on the first day of the next month.

#### C. REINSTATEMENTS OF WAIVER RECIPIENTS FOLLOWING NURSING HOME STAYS

If a client has a short stay in a nursing facility of 100 days or less and is still within the active redetermination period, the following processes should occur:

1. Once the recipient is admitted to the nursing home, the OA must submit the waiver end date to the LTC system by using the LTC Notification Software indicating the recipient is discharged from the waiver.
2. A reassessment must be completed and services resumed within ten (10) days from the nursing home discharge date. The OA will enter a new begin date for the reinstatement by using the LTC Admission Notification Software. The CM must conduct a face-to-face visit before services are resumed.
3. The full HCBS Application must be updated, with the exception of the Admission and Evaluation Data form (Medical).
4. The HCBS plan of care start dates must be updated for all services—including case management services.

5. The course of events related to the nursing home admission and discharge should be clearly documented on the HCBS Waiver application, to the extent possible, to reflect nursing home admission date, nursing home discharge date and date the waiver services were ended and resumed. It is understood that in some instances the OA may not be notified by the family of the recipient's discharge from the nursing facility. The OA will resume services as soon as possible but not later than 10 days after notification occurs
6. A Reinstatement is not applicable if a client's total number of days off of the waiver for any reason exceeds 100.

Waiver recipients whose redetermination period expires before the recipient is discharged from the nursing home or who fails to begin services within ten (10) days of discharge from the nursing home must be submitted as a waiver re-admission.

#### D. TERMINATIONS

1. Termination of waiver services
  - a. Services must be officially terminated if a client no longer requires or becomes ineligible to receive the service. Waiver services may be terminated at any-time during a waiver approval period.
  - b. When a change in the client's needs suggests a change in services included in the client's plan of care, the CM will discuss the proposed change with the client, responsible party, and/or significant other before implementation and/or before issuing a written advance notice. The discussion will include an explanation of the reason for the change, impact of the change, and an agreement, if possible, of the client, responsible party, and/or significant other to the change.
  - c. When TA Waivers for Adults services are suspended, terminated, or reduced to coincide with the client's justifiable need, the service definition, and/or eligibility for the service, written advance notice is required at least

ten calendar days before the effective date of action, with the following exceptions:

- (1) A written statement is provided by the client, responsible party, and/or significant other which specifies that services are no longer needed or wanted and/or there is an agreement to reduced, suspended, or terminated services;
- (2) The client moves to another county and TA Waiver for Adults services are being provided in that county;
- (3) The client transfers to another waiver program;
- (4) The client moves out of state;
- (5) The client dies;
- (6) The client moved and left no forwarding address and his or her whereabouts are unknown as verified by return of agency mail;
- (7) The client enters a nursing home, hospital, or other facility where services cannot be provided according to policy;
- (8) The client is no longer financially eligible; and,
- (9) The client, responsible party, and/or significant other request by telephone that services be reduced, suspended, or terminated.

**The above exceptions are not a definitive list. If an unprecedented situation occurs the AMA should be contacted.**

- d. TA Waivers for Adults services as on the plan of care at the time the notice was given are to be continued from the date of the written notice and the effective date of the adverse action unless:
  - (1) Providing services result in a danger to the health and safety of the service provider(s);
  - (2) Providing services is against the expressed wishes of the client, responsible party, and/or significant other;
  - (3) There is no willing provider available.

## 2. Noncompliant Client

- a. If a client, responsible party, and/or significant other refuses to cooperate with the TA Waiver for Adults program and all alternatives (i.e., counseling, personal contacts, referrals to interagency team staffing, CM/supervisory visits, etc.) have been exhausted, termination of the waiver services and/or termination from the TA Waiver for Adults program may be appropriate.
- b. Examples of noncompliance include but are not limited to:
  - (1) Repeated refusal to cooperate with providers and/or CMs;
  - (2) Repeated incidences of noncompliance with the plan of care;
  - (3) Physical abuse or repeated verbal abuse toward provider and/or CM;

(4) Conduct which adversely impacts the program's ability to ensure service provision or to ensure the client's health, safety, and welfare.

c. If termination of a waiver service for noncompliance is being considered, the following must occur:

(1) All efforts made in working with the client, responsible party, and/or significant other must be carefully documented;

(2) Termination of services must be prior approved by authorized staff at the OA;

(3) Client must be notified of termination of service;

(4) The service contract must be sent to the provider to terminate services.

(5) The client, responsible party, and/or significant other must be notified in writing by certified mail of the program requirements, advised of potential consequences of continued noncompliance and given an opportunity to remedy the circumstances. The letter must have the authorized staff at the OA approval prior to sending to the client.

## CHAPTER 6

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### APPEAL RIGHTS

The AMA LTC Division is responsible for the administration and oversight of the HCBS Programs. Any Medicaid applicant or recipient has the right to request an appeal of any decision by the administering or OA which adversely affects his or her eligibility status for receipt of services and/or assistance. The AMA will provide an opportunity for a fair hearing under, 42 CFR part 431, subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to institutional care, or who are denied the services of their choice or the providers of their choice. In a cooperative effort, the State and the OA have procedures in place to assure CMS that at the time of application due process of client rights to a fair hearing is explained to a potential client. Due process consists of a right to an informal conference or to a fair hearing if client's request for waiver services is denied, terminated or reduced.

#### A. TEN (10) DAY ADVANCE NOTICE

1. When services have been reduced or terminated, the CM should send a 10-day advance notice to the client prior to the reduction or termination of services. When the client receives this notice, they have 10 days following the effective date of action taken to request an informal conference in writing.
2. The OAs are responsible for explaining the procedures when services have been reduced, suspended, or terminated under the waiver and that the written notice includes:
  - a. A description of the action the agency intends to take,
  - b. The reasons for the intended action,
  - c. Information about the participant's rights to request a hearing, and

- d. An explanation of the circumstances under which Medicaid services will continue if a hearing is requested.
3. A copy of the written plan of care includes information on the appeal rights and the steps to appeal an adverse decision. A copy of this information is left in the client's home.

## B. INFORMAL CONFERENCE

The client has ten (10) days from the effective date of action to request an informal conference. The client may notify the AMA in writing giving the reason for the dissatisfaction and ask for either an informal conference or a review of the case by the AMA. At the informal conference, the client may present the information and/or may be represented by a friend, relative, attorney, or other spokesperson of their choice. Services cannot be continued pending the results of an informal conference, unless a fair hearing is also requested within 10 days of the effective date of the action.

## C. REQUEST A FAIR HEARING

1. If the client is still dissatisfied after the above procedure has been completed, a fair hearing may be requested. A written request for a hearing must be filed within sixty (60) days following the action with which he or she is dissatisfied. The client or legally appointed representative or other authorized person must request the hearing and give a correct mailing address to receive future correspondence. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he or she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and a hearing date and place convenient to the person will be arranged.

If a client wishes to continue services while awaiting the fair hearing results, the written request for a fair hearing must be received within 10 days of the effective date of action and must specifically request the continuation of services in the interim.

2. If the person is satisfied before the hearing and wants to withdraw the request, the client or legally appointed representative or other authorized person should write the AMA that he or she wishes to do so and give the reason for the withdrawal.

#### D. COMPLAINTS AND GRIEVANCES

1. Alabama Department of Rehabilitation Services (ADRS) is responsible for explaining the procedures to clients of filing complaints and grievances. ADRS must have procedures in place that will assure AMA that Direct Service Providers (DSP) have explained to clients the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or AMA.
  - a. Complaints are submitted to ADRS or the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions of the incident in the Waiver Quality Assurance (QA) Unit at AMA. The OA will also maintain a log of complaints and grievances received.
  - b. If complaints are received by the AMA, a copy will be forwarded to ADRS within two (2) working days. A summary and plan of correction will be sent from the OA to the AMA Waiver QA unit for all complaints reported within 30 days of the request for the summary or plan of correction from the AMA. The providers must forward their plan of correction to the OA who will in turn forward to AMA. The AMA will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the OA within two (2) days. The revised plan of correction will be resubmitted to the AMA within two (2)

working days. If the summary or plan of correction carried out is found not to be responsive, the OA will have up to seven (7) days to revise the plan and carry out the appropriate action.

- c. If complaints are received by ADRS a copy will be forwarded to the AMA within two (2) working days, if the client's health and safety are at risk. Otherwise, the complaint/grievance should be entered onto the log that is submitted to the AMA quarterly. ADRS must investigate all complaints upon receipt of notification. Appropriate parties must initiate action within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed.
- d. A summary and plan of correction will be sent from the provider to the OA for all complaints reported within 30 days of the request for the summary or plan of correction from the OA. The providers must forward their plan of corrections to the OA who will in turn forward to AMA. The OA will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the provider within two (2) days. The revised plan of correction will be resubmitted to the OA within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the provider will have up to seven (7) days to revise the plan and carry out the appropriate action.
- e. ADRS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risks exist.
- f. Final determinations including any adverse findings will be reported to the AMA.
- g. The AMA will contact the client via telephone to ensure full resolution to the incident has been completed satisfactorily.

- h. ADRS will forward all grievance logs to AMA Waiver QA Unit quarterly for review, tracking, and assurance that resolutions have been completed.

## **CHAPTER 7**

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### **COVERED SERVICES**

#### **A. HOME AND COMMUNITY-BASED WAIVER SERVICES**

The purpose of home and community-based waiver services is to provide realistic options for clients who need help to remain at home and avoid unnecessary or premature admission to a nursing home.

Home and community-based waiver services are provided by DSP who are contracted and enrolled as Medicaid providers to render services to eligible clients. These services are:

- |                                      |          |
|--------------------------------------|----------|
| • Skilled Nursing RN                 | S9123 U5 |
| • Skilled Nursing LPN                | S9124 U5 |
| • Personal Care / Attendant Services | T1019 U5 |
| • Medical Supplies and Appliances    | T2028 U5 |
| • Assistive Technology               | T2029 U5 |

A description of each covered service is included in this chapter and is part of the contractual agreement, which defines both providers' and OA's responsibilities in the provision of waiver services.

Waiver services should be authorized only when other formal community resources are not available to meet the client's needs. For example, if a volunteer meals program is available in the community, a referral should be made to access this resource.

An agency's maintenance of effort is vital in assuring that home and community-based waiver services are cost-effective programs. Maintenance of effort means that an agency will continue to provide services that the agency has in place once TA Waiver for Adults services have been implemented. It is important that state agencies, their affiliates, and other local organizations make every effort to maintain existing services to long term care clients and to provide additional services when appropriate in order to satisfy the maintenance of effort requirement.

If an agency discontinues a service, the CM should contact that agency to determine if it is a temporary or permanent interruption and then document the findings in the narrative accordingly.

Moreover, a client's family and/or caregiver should continue their efforts in caring for that person. In most situations, home and community-based waiver services should not replace the informal caregivers' support, but should supplement their efforts.

In summary, waiver services should only be authorized to meet the client's needs as specified in the Plan of Care and must be based on the availability of other non-Medicaid Services.

## B. CHOICE OF WAIVER SERVICE PROVIDERS

1. A client, responsible party, and/or significant other must make a choice of providers for each waiver service that he or she desires. The initial choice is documented in the narrative, during the assessment visit. The CM should supply a list to the client, responsible party, and/or significant other of all providers listed in alphabetical order for all waiver services available in the area. These waiver services should be discussed with the client, responsible party, and/or significant

other during the CM's initial visit. At the initial assessment visit, a written choice should be made for each waiver service that the client desires to access. Subsequent changes or additions of providers are made verbally and documented in the narrative. It is important that the client, responsible party, and/or significant other make this decision independently, and the CM is cautioned not to influence a client's choice of providers.

2. If a client is not physically or mentally able to complete and/or sign a Choice of Provider form, the responsible party or significant other may do so for the client. The lack of a signature on the form will not preclude the client from receiving waiver services.
3. The client, responsible party, and/or significant other will be encouraged to choose at least three providers. If more than two providers are available for the chosen service, the client must prioritize the choices by numbering them "1", "2", and "3".
4. It is the responsibility of each OA to keep an updated list of providers for each waiver service available in the geographical area. A copy of this list is given to each client, responsible party, and/or significant other at each redetermination visit, so the client will always be informed of providers serving his or her area.
5. If at any time the client, responsible party, and/or significant other request an additional waiver service or a change in providers, the CM will inform the client, responsible party, and/or significant other of all available providers of the service(s) in question. The CM must document this information exchange as well as the client's choice of provider(s).
6. Special needs of the client, such as weekend service or specific hours of the day or evening, should be reflected on the Service Authorization Form and documented in the narrative. These needs should be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral.

7. Because the condition of the client is the primary consideration and the timely initiation of services is paramount, the CM will have the option of referring to the next provider (as prioritized by the client, responsible party, and/or significant other) if an affirmative response has not been received from the chosen provider within three (3) working days. The same will hold true if the chosen provider does not respond to a “call-back” message. When this occurs, dates and persons contacted and other pertinent information must be documented in the narrative.

## C. CONTRACTING FOR WAIVER SERVICES

1. Prior to contracting for any waiver services, the CM must be familiar with all services. Waiver services are based on a client’s need as documented in the plan of care. The plan of care should be a clear, factual representation of the client’s need and support the rationale and appropriateness for a service authorization.
2. Prior to initiating a service authorization, the CM must contact the provider to determine the start date and discuss any special needs to the client. Identification is required of the client whose needs are such that the absence of an authorized waiver service would have a substantial impact on the client’s health and safety. In cases where the client is determined to be at risk for missed visits, the authorization will be flagged when initiated. The existing authorization is revised and sent to the provider indicating the current status if the at-risk status changes.
  - a. “Client-at-risk” - A client whose special needs and/or support situations are such that the absence of an authorized waiver service would have a substantial impact on the client’s health and safety and there are no other reliable support systems to perform this duty. (Example: Client who is bedbound and relies on a PCW to get him/her out of bed in the morning and there are no other reliable support systems to perform this duty).
  - b. Missed visits for clients at risk

Once the client is identified as being at-risk for a missed visit the information is entered on the Service Authorization Form. The service

authorization form must be flagged alerting the provider that the client has special needs.

c. Emergency/disaster priority

The emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a client who would be vulnerable during the emergency/disaster:

- (1) **Not Priority** - Client is not vulnerable during emergency/disaster or has adequate supports to meet his or her needs. (Example: Client with functional deficits, but family willing and able to evacuate and/or meet needs.)
- (2) **Priority, Client Lives Alone** - Client lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Client lives alone and has no one available to evacuate him or her or has no one to give insulin.)
- (3) **Priority, Advanced Medical Need** - Client has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Client is on ventilator, dialysis, or other specialized equipment/service.)

3. The Service Authorization Form must be specific and accurate, including the appropriate service. It must also include the number of units per day and days of the week (e.g. "2 units 3 x weeks - MWF"). The hours of service should appear on the form only if the hours indicate specific times which are essential to meeting the clients' service needs. Unless specific hours are absolutely essential, rejection of a provider due to inability to provide requested hours is neither appropriate nor allowable. The provider must, however, be given the opportunity to accept or reject the hours. The CM must ascertain that such specific hours requested are required and not simply desired by the client. Desired hours may, of course, be

negotiated with the client and with the provider during the provider's initial contact.

4. CMs must contact the client, responsible party, and/or significant other within ten (10) working days after the service authorization start date to ensure services are implemented and to review client/agency responsibilities. This contact may be made either by telephone, home visit, or in written form. Follow-up contact with the provider(s) may be necessary to resolve questions or problems with contracted services. Regular contact must be maintained with the providers of waiver services.

#### D. CHANGES IN SERVICES WITHIN A CONTRACTED PERIOD

1. A permanent or temporary change in contracted services necessitates a revision on the Service Authorization Form. The type of change, permanent or temporary, must be indicated on the plan of care and documented clearly in the narrative.
2. A temporary change (increase in the number of units or change in authorized days) can be made for a period of 30 calendar days. Any change exceeding the 30 calendar days must be considered permanent for the purposes of the service authorization. A verbal approval to providers may be given for a temporary change in the number of units or days. This change must be followed by completion of a revised Service Authorization Form, which should be sent to the provider. Temporary changes should be noted on the form as a temporary change denoting the start and end dates. The services will then revert back to the authorized service schedule as indicated on the latest service authorization form.
3. New waiver service(s) may be added at any time, according to the client's need as long as the service or combination of services does not show the client needs 24-hour care. It must be documented in the narrative the reason why these changes are necessary.

## E. REEVALUATION OF NECESSITY OF WAIVER SERVICES

Reevaluation of a waiver service occurs annually or any time that a reevaluation is necessary to assess the need for waiver services. At this time, the CM must make an informed decision regarding the continuation and/or revision of waiver services.

1. Interruption of waiver services may occur for one of the following reasons:
  - a. Client enters the hospital or institution (i.e., rehabilitation center, MR/MH facility) for a temporary stay; or
  - b. Client is in the community but chooses not to receive services temporarily (Example: client has a doctor appointment, client goes out of town, client declines substitute worker).
2. The effective date of the interruption is the first date the service was not provided. Services must be interrupted retroactively regardless of when the OA is notified of the need for interruption.
3. Interruptions of waiver services are reported to the CM by the service provider on a weekly basis with the Missed Visit and Service Interruption Report. The CM must document in the narrative when the client is hospitalized or institutionalized; narration of other interruptions in service reported by the provider is mandatory.
4. The service authorization remains open when the services are interrupted. However, the CM may choose to terminate waiver services if the services are to be interrupted for an extended time. (Example: Client goes on a planned, out-of-state visit that is scheduled to last more than 60 days.) However, the CM may decide that a formal notification to the client, responsible party, and/or significant other is beneficial in some cases.
5. Interruption in service reported by the client, responsible party, and/or significant other (excluding calls received from providers) must be documented explaining

the reason for interruption in services. This includes phone calls received from the client, responsible party, and/or significant other, as well as information obtained by the CM during the monitoring process. The Internal Missed Visit Report Form serves as documentation of the internal missed visits reporting.

## CHAPTER 8

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### PROVIDERS

#### A. CONDITION FOR PARTICIPATION

##### 1. Definition of Agency

- a. To participate in the HCBS TA Waiver for Adults program, a provider of service shall meet the licensure and certification requirements as outlined in the waiver. On-site reviews of each service provider shall be conducted initially and annually thereafter, unless otherwise specified in the waiver document. The participating service providers shall furnish services under contractual arrangement with the AMA and the OA.

Clients shall not be placed on waiting lists for services which the provider of direct in-home services cannot deliver.

- b. Agreements made by the OA with direct service providers shall be in writing. These agreements shall stipulate that receipt of payment by the OA for the service (whether in its own right or as an agent) relieves any liability on the part of the Medicaid client to make any additional payment.
- c. Providers have the right to limit the number of Medicaid recipients they are willing to serve; however, providers may not discriminate in selecting the Medicaid recipients they will serve.

##### 2. Record Requirement

- a. The CM and OA shall be required to maintain for each recipient clinical records which cover the waiver services provided and nonwaiver services provided by other direct service providers. These records must contain

pertinent, past and current medical, nursing, social and other information including the comprehensive assessment and plan of care.

Signature stamps on documents are unacceptable. However, if one has to be used it must be initialed by the person who is signing the document.

- b. The OA and the provider of direct service shall furnish any required requested information to the AMA.
  
- c. All information on TA WAIVER FOR ADULTS program applicants and recipients, including those person referred to the TA WAIVER FOR ADULTS program shall be safeguarded in accordance with the provisions of the Code of Federal Regulations governing confidentiality (CFR 42 431.305).
  - (1) Confidential information includes but is not limited to:
    - (a) The name and address of the individual served and the service they received;
  
    - (b) Medical data, including diagnosis and past history of disease or disability;
  
    - (c) Agency evaluation of information about a person;
  
    - (d) The identity of persons or institutions that furnished health services to a person;
  
    - (e) The social and economic conditions or circumstances of any person served; and

(f) Federal program information identified as confidential by appropriate federal authority.

d. All OA personnel, direct service provider personnel, persons receiving services through the TA WAIVER FOR ADULTS services and all other persons dealing with TA WAIVER FOR ADULTS service shall be informed of the agency's policies and regulations with respect to safeguarding of confidential information.

## B. FINANCIAL ACCOUNTABILITY OF PROVIDERS

1. The financial accountability of providers for funds spent on HCBS must maintain a clearly defined audit trail. Providers must keep records that fully show the extent and cost of services provided to eligible clients for a five year period. These records must be accessible to the AMA and the 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 providers of this waiver will have their financial records audited at least annually at the discretion of the AMA. Payments are adjusted to actual cost and if there is an underpayment found payment would be made. If an overpayment is found, the AMA will recover funds.
3. The AMA will review at least annually, a sample of clients and services provided through the TAW. The review will include the appropriateness of care provided and proper billing procedures.
4. The providers of the TAW will provide documentation of actual costs of services and administration. Such documentation will be entitled "Quarterly Cost Reports for the TAW". The Quarterly Cost report will include all actual costs incurred by the OA for the previous quarter and costs incurred year to date.
5. This document will be sent to the AMA before the 1st day of the third month of the next quarter.

- a. 1st October - December Due before March 1st
  - b. 2nd January - March Due before June 1st
  - c. 3rd April - July Due before October 1st
  - d. 4th August - October Due before January 1st
6. Failure to submit the actual cost documentation may result in the AMA deferring payment until this documentation has been received and reviewed.

### C. AUDITING STANDARDS

- 1. Office of Management and Budget (OMB) Circular A-87, “Cost Principles for State and Local Governments” will apply to governmental agencies participating in this program. For nongovernmental agencies, accepted accounting principles will apply. Governmental and nongovernmental agencies will use the accrual method of accounting unless otherwise authorized by the AMA.

### D. ALLOWABLE, UNALLOWABLE COSTS

- 1. 45 CFR part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the \$2500 limit require the approval of Medicaid.
- 2. OMB Circular A-87 establishes cost principles for governmental agencies and will serve as a guide for nongovernmental agencies. For governmental agencies all reported costs will be adjusted to cost at the end of the year.
- 3. Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for home and community-based waiver services are recognized expenses. All other contracts will require Medicaid approval to insure that functions are not being duplicated. For example, outreach is to be performed by the case manager; thus, it would not be proper to approve other contracts for outreach unless it can be clearly shown that the function is needed and cannot be provided within the established organization.
- 4. Allowable Costs

- a. Allowable costs are defined in the OMB Circular A-87. However, the following restrictions apply:
  - (1) Advertisement is recognized only for recruitment of personnel, solicitation of bids for services of goods, and disposal of scrap surplus. The cost must be reasonable and appropriate.
  - (2) The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding \$25,000 will be capitalized in accordance with 45 CFR 95.705 and depreciated through a use allowance of 2 percent of acquisition cost for building and  $6\frac{2}{3}$  percent for equipment, see 45 CFR 95.641. When approval is required, the request will be submitted to the AMA in writing.
  - (3) The acquisition of transportation equipment will require prior approval from the AMA. When approval is required, the request will be made to the AMA in writing.
  - (4) Transportation is an allowable expense to be reimbursed as follows:
    - (a) For nongovernmental agencies, it will be considered as part of the contract rate.
    - (b) For government and private automobiles utilized by state employees, reimbursement will be no more than the current approved state rate.
    - (c) All other types transportation cost will be supported by documents authorizing the travel and validating the payment.

## 5. Unallowable Costs

- a. The cost of advisory councils or consultants without AMA's approval.
- b. Legal fees are as follows:

- (1) Retainers,
- (2) Relating to fair hearings,
- (3) In connection with lawsuits which result in an adverse decision,
- (4) Services that duplicate functions performed by Medicaid or the provider such as eligibility determination for the program,
- (5) Other legal fees not relating to providing services to the beneficiaries, and
- (6) Dues and subscriptions not related to the specific services.

**E. COST ALLOCATION PLANS**

1. State agencies must 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 CFR 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.
2. 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 within a fund, there must be a plan in writing to distribute the cost among the projects. 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 some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage.

- The second type of allocated cost falls under the administration definition. For example, a case manager that spends time on two individuals (or group of people) that have not attained waiver eligibility. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.
3. Contracts, which are used for buying services from other governmental agencies, must be cost-allocated. As a minimum, these contracts should meet the requirement of 45 CFR 95.507. These contracts must show:
- a. The specific services being purchased,
  - b. The basis upon which the billing will be made, i.e., time reports, number of homes inspected, etc.,
  - c. A stipulation that the billing will be based on actual costs incurred. This is not a requirement for nongovernmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the fiscal year.