

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA**

JONATHAN PAUL BOYD,

Plaintiff,

v.

CAROL H. STECKEL, in her
official capacity as Commissioner of the
Alabama Medicaid Agency,

Defendant.

Case No.: 2:10cv688-TFM

**PLAINTIFF'S AMENDED MEMORANDUM OF LAW IN SUPPORT OF HIS
MOTION FOR PRELIMINARY INJUNCTION AND EXPEDITED HEARING**

I. Background

Plaintiff Jonathan Paul Boyd is a 34 year old man who, as a result of an accident when he was 19, is paralyzed from his collarbone down. He uses a motor wheelchair for ambulation and controls it with a "sip and puff" device. For eleven years after his accident he lived at home with his mother as his primary caregiver. In 2006 Mr. Boyd's mother could no longer provide the care he required. As a result Mr. Boyd, who is Medicaid eligible, has been in a nursing home since December 2006. (Exh. A, Amended Declaration of Mr. Boyd.)

In the nursing home, Mr. Boyd receives assistance with his activities of daily living, including assistance with taking medications, bathing, dressing, toileting, feeding, and transferring from and to his bed and into and out of his wheelchair. He receives assistance with household chores. He receives assistance twice weekly for his bowel program and twice monthly for changing his catheter. In order to live in the community, Mr. Boyd needs Defendant to provide him with community-based services including ten

hours per day of assistance with activities of daily living, assistance with his bowel program twice per week, assistance with changing his catheter twice per month, and necessary equipment and care supplies. These services could be provided to Mr. Boyd in the community by Defendant's Medicaid program through a waiver, a combination of waivers, or reasonable modification of waivers. (Exh. A, Amended Declaration of Mr. Boyd.)

Defendant pays for Mr. Boyd's placement and services in the nursing home with Medicaid funds. If Defendant would provide Mr. Boyd with necessary and appropriate services in the community, Mr. Boyd could live in the community. Two years ago, Mr. Boyd applied for Defendant's Medicaid community-based waiver services and continues to be on a waiting list for services. Mr. Boyd, through his attorneys, recently renewed his request for services by asking Defendant provide Mr. Boyd with the necessary and appropriate services he requires in order to live in the community. However, Defendant has not granted Mr. Boyd's request. (Exh. A, Amended Declaration of Mr. Boyd; Exh. B, Demand Letter to Medicaid counsel; Exh. C, Emails with Medicaid counsel.)

Mr. Boyd has earned a B.A. degree from University of Montevallo. Recently, he was accepted into a Master's program at the University of Montevallo and began that program in September 2010. Upon receiving his Master's degree, he will have skills to obtain employment and be a taxpaying member of society. He wants to live near campus which would allow him to readily and independently travel to classes, assignments, and other University activities. He has located accessible rental housing for this purpose, which will be available for occupancy in January 2011, in time for the beginning of his next semester of graduate school. However, he cannot move forward with his plans to

secure rental of that housing until he knows whether he will be provided with necessary and appropriate community-based services by the Defendant. Accessible rental housing is difficult to locate and secure, so he needs to act as soon as possible to secure housing. (Exh. A, Amended Declaration of Mr. Boyd.)

Because Mr. Boyd lives in the nursing home, rather than near campus as he prefers, he cannot travel readily and independently to campus. For that reason: he is only taking two classes per semester instead of four; he has to rely upon and pay a nursing home maintenance worker his entire scholarship amount (\$500) to transport him to and from campus for his classes; he has to pay others \$20 per trip (borrowed from his brother) to transport him to and from campus on six occasions this semester to complete required assignments and; he is prevented from engaging in various other activities of college life (athletic events, author readings, theatrical performances and musical performances). Without Defendant's providing necessary services in the community, Mr. Boyd will continue to suffer in this manner. (Exh. A, Amended Declaration of Mr. Boyd.)

As a result of living in the nursing home: Mr. Boyd has experienced more decubitus ulcers (pressure sores); his daily care schedule is dependent upon the schedules of staff and other residents; his ability to go into the community for social purposes with friends and family is inhibited; most other residents at the facility are much older than he is; activities at the nursing facility are not geared to his age group; his diet and eating schedule are determined by the staff; the nursing facility environment subjects him to noise, crying, odors, and exposed residents; he only receives \$30 from his Social Security Disability benefits of \$897 and; he has no privacy. Without Defendant's providing necessary services in the community, Mr. Boyd will continue to suffer in this manner.

(Exh. A, Amended Declaration of Mr. Boyd.)

II. Plaintiff Boyd Meets the Standards for Preliminary Injunctive Relief

The criteria for granting a preliminary injunction are: (1) a strong likelihood of success on the merits, (2) the possibility of irreparable injury to plaintiff if the preliminary relief is not granted, (3) a balance of hardships favoring the plaintiff, and (4) advancement of the public interest. *See All Care Nursing Serv., Inc. v. Bethesda Mem'l Hosp., Inc.*, 887 F.2d 1535, 1537 (11th Cir. 1998). The grant or denial of a preliminary injunction is almost always based on an abbreviated set of facts, requiring a delicate balancing of the probability of ultimate success at final hearing with the consequences of immediate irreparable injury, which could flow from the denial of preliminary relief. *Revette v. Int'l Ass'n of Bridge*, 740 F.2d 892, 893 (11th Cir. 1984).

In this case, Plaintiff Boyd raises a very strong likelihood of ultimate success on the merits under the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (“ADA”), the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) (“Section 504”), and the implementing regulations for both statutes; a very strong probability of irreparable injury; and both the balance of hardships and public interests weigh significantly in his favor. Accordingly, Plaintiff Boyd is entitled to preliminary injunctive relief.

III. Likelihood of Success

A. Defendant's Responsibilities under the HCBS Waiver

Medicaid is a joint federal/state program authorized by Title XIX of the Social Security Act. 42 U.S.C. §§ 1396-1396v. It provides medical assistance to low income individuals who meet certain eligibility requirements. States are not required to participate in the Medicaid program. If a state elects to participate, however, it is

required to comply with all applicable federal statutory and regulatory requirements. 42 U.S.C. § 1396a; *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Harris v. James*, 127 F.3d 993, 996 (11th Cir. 1997).

Medicaid home and community-based services (HCBS) waiver¹ programs are authorized by 42 U.S.C. § 1396n(c). These Medicaid programs enable states to provide home and community-based services to individuals with disabilities who otherwise would need the level of care provided in the institutional nursing home. Medicaid waiver programs must be cost-neutral, in the aggregate, in that the total average cost of providing care for program participants in the home and community based setting must not exceed the estimated total average cost of providing care in the institutional setting that these participants would require. 42 U.S.C. §1396n(c)(2)(D), 42 C.F.R. §441.302(e).

Defendant's Medicaid waiver is capped at 9,205 people and has been at this cap since 2008. (Exh. D, Alabama Medicaid chart on waiver programs.) According to the Kaiser Commission, there were 7,094 people on the waiting list for community-based services under Defendant's Elderly and Disabled Waiver. (Exh. E, Kaiser Commission's Medicaid Home and Community-Based Service Programs Data Update, p. 39.) Alabama's Medicaid nursing home reimbursement is approximately \$33,700 a year. (Exh. F, Alabama Medicaid CMS waiver application, appendix J-1: 1.) The Medicaid waiver for home and community-based services is approximately \$10,365. (Exh. F, Alabama Medicaid CMS waiver application, appendix J-2: 5.) Thus, for each person

¹ States that opt to provide waiver services may "waive" requirements such as statewideness, comparability and income requirements for which a state's other Medicaid services and programs must otherwise comply with 42 U.S.C. §1396n(c)(3). The Secretary of the Department of Health and Human Services has approved waivers in Alabama for people who would otherwise require care in a nursing facility.

Alabama diverts from the nursing home and provides waiver services in the community, Alabama and the federal government save approximately \$22,000 a year.

B. The ADA and Section 504

Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) (“Section 504”) is “commonly known as the civil rights bill of the disabled,” *Americans Disabled for Accessible Public Transp. (ADAPT) v. Skinner*, 881 F.2d 1184, 1187 (3d Cir. 1989) (*en banc*). Section 504 of the Rehabilitation Act of 1973 expressly prohibits disability-based discrimination by recipients of federal funding, such as Defendant. 29 U.S.C. § 794(a).

Extending the prohibitions of Section 504, in 1990 Congress enacted the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (“ADA”), to prohibit discrimination by all public entities, regardless of whether they receive federal funding. H.R. Rep. No. 101-485, pt. 3, at 49 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 472. Like Section 504, Title II of the ADA broadly prohibits discrimination by public entities, such as Defendant’s agency. 42 U.S.C. §§ 12131(1), 12132.²

Title II of the ADA bars unnecessary institutionalization and segregation of people with disabilities and prohibits such discrimination by public entities. 42 U.S.C. § 12132. In enacting the ADA, Congress for the first time stated that “institutionalization” was a “critical area” where discrimination persisted. 42 U.S.C. § 12101(a)(3). Congress explicitly noted that discriminatory practices continued through “segregation.” 42 U.S.C.

² The ADA and Section 504 are analyzed together since “there is no significant difference in the analysis of rights and obligations created by [the two].” *Zulke v. Regents of the Univ. of Calif.*, 166 F.3d 1041, 1045 n.11 (9th Cir. 1999). The ADA provides that the “remedies, procedures, and rights set forth in [Section 504] shall be the remedies, procedures and rights [applicable to ADA claims].” 42 U.S.C. § 12133.

§ 12101(a)(5).³ Mr. Boyd is both unnecessarily institutionalized and segregated in the nursing facility as a condition of receiving services through Defendant's funding.

Title II of the ADA prohibits public entities from discriminating against persons with disabilities. 42 U.S.C. § 12132.⁴ A "qualified individual with a disability" is a person who "with or without reasonable modifications to rules, policies or practices" meets the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). Defendant does not dispute that Plaintiff Boyd is a qualified person with a disability who meets the eligibility requirements for Alabama's Medicaid nursing home "level of care" as well as for its waiver and Medicaid programs.

C. The ADA and Section 504's Integration Mandate

In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court faced the question of whether a state has an obligation under the ADA to provide community services to

³ The concept of "discrimination" under the ADA and Section 504 encompasses more than disparate treatment of people with disabilities vis-à-vis individuals without disabilities. See *Olmstead v. L.C.*, 527 U.S. 581, 598 (1999) (ADA); *Alexander v. Choate*, 469 U.S. 287, 297, 300-01 (1984) (Section 504); *Helen L. v. DiDario*, 46 F.3d 325, 333, 335 (3d Cir. 1995), *cert. denied*, 516 U.S. 813 (1995) (ADA); *Nathanson v. Medical College of Penn.*, 926 F.2d 1368, 1384 (3d Cir. 1991) (Section 504).

⁴ Similarly, Section 504 prohibits the recipients of federal funds from discriminating on the basis of disability:

No otherwise qualified individual with a disability...shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....

29 U.S.C. §794(a).

people with disabilities who are segregated and unnecessarily institutionalized. The Supreme Court in *Olmstead* concluded, “[u]njustified isolation ... is properly regarded as discrimination based on disability.” *Id.* at 597. Explaining that “unjustified institutional isolation of persons with disabilities is a form of discrimination,” the Court declared, “[c]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment.” *Id.* at 600-1.⁵

In *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003), Oklahoma provided needed Medicaid services only if the plaintiffs went into nursing homes. The plaintiffs wanted to remain integrated in the community. The Tenth Circuit noted that the ADA’s integration protections:

would be meaningless if plaintiffs were required to segregate themselves by entering an institution.... [N]othing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA’s integration requirements.

Id. at 1181.

Under both the ADA and Section 504, Congress directed the Department of Justice (DOJ) to promulgate regulations to implement Title II. 42 U.S.C. § 12134; 29 U.S.C. § 794(a). Adhering to Congress’s statutory mandate that institutionalization and segregation were to be prohibited, DOJ adopted regulations to implement Title II. *See* 28

⁵ *Olmstead* has been applied by a number of federal appellate courts in cases involving individuals with disabilities who are at risk of unnecessary institutionalization. *See, e.g., Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004); *Townsend v. Qasim*, 328 F.3d 511 (9th Cir. 2003); *Pennsylvania Protection & Advocacy, Inc. v. Pennsylvania Dep’t of Public Welfare*, 402 F.3d 374 (3d Cir. 2005).

C.F.R. § 35.130(d).⁶ For purposes of implementing Title II of the ADA, the Attorney General promulgated a regulation requiring public entities to “administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). The regulation was based upon virtually identical regulatory language promulgated to implement Section 504 with respect to federal financial recipients. 28 C.F.R. § 41.51(d).⁷

The integration mandate was analyzed and interpreted by the United States Supreme Court in the landmark decision of *Olmstead v. L.C.*, 527 U.S. 581 (1999). The *Olmstead* plaintiffs were individuals with mental disabilities who were confined in Georgia’s state psychiatric institutions, but who wanted to live in the community. Plaintiffs asserted the state’s refusal to pay for them to live in community settings violated the integration mandate of Title II of the ADA and its implementing regulations. The Court was thus presented with the question whether the proscription of disability discrimination may require the placement of individuals with disabilities in community settings rather than institutions. *Id.* at 587. The Court’s decision was premised on the DOJ integration regulation, 28 C.F.R. § 35.130(d).

The Court began its analysis by citing the relevant Congressional findings that serve as the underpinnings for the ADA:

(2) ... historically, society has tended to *isolate and segregate* individuals

⁶ Congress further directed that the regulations promulgated under Title II of the ADA be consistent with the regulations adopted under Section 504. 42 U.S.C. §12134(b).

⁷ These two regulations, known as the “integration mandate,” are construed and applied in the same manner. *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1179 n.3, 1180-81 (10th Cir. 2003).

- with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive societal problem;
- (3) discrimination against individuals with disabilities persists in such critical areas as...*institutionalization*...; ...
 - (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion...*failure to make reasonable modifications to existing facilities and practices, [and] segregation*...

42 U.S.C. §12101(a)(2), (3) & (5) (emphasis added) (quoted in *Olmstead*, 527 U.S.at 588-89).

After noting the comprehensive scope of discrimination embraced by the ADA, the *Olmstead* Court explained the nature of discrimination prohibited by Title II of the ADA in the context of the integration mandate:

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons *who can handle and benefit from community settings* perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Second, *confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment*. Dissimilar treatment exists in the key respect: In order to receive needed medical services, persons with ... disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without [such] disabilities can receive the medical services they need without similar sacrifice.

Id. at 600-601 (citations omitted; emphasis added). Accordingly, the Court concluded more than eleven years ago: “unjustified isolation, we hold, is properly regarded as discrimination based on disability.” *Id.* at 597.

The facts of the case at bar clearly demonstrate that Plaintiff Boyd is suffering and will continue to suffer unnecessary discrimination. For Plaintiff Boyd the “most integrated setting” is in the community in his own home or apartment. By living outside

the nursing facility and participating in community life, especially the life of Montevallo, Boyd will experience and benefit from the social contacts, educational advancement and cultural enrichment of which the Supreme Court spoke. Being forced to remain confined in a nursing home solely to receive the services that Boyd needs is precisely the sort of discrimination outlawed by the Supreme Court in *Olmstead*, 527 U.S. at 601 (recognizing discrimination where, “[i]n order to receive needed medical services, persons with [] disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without [] disabilities can receive the medical services they need without similar sacrifice. See Brief for United States as Amicus Curiae 6-7, 17.”). Defendant’s refusal to provide Medicaid funds for Mr. Boyd in the community and its failure to grant a reasonable modification to its existing Medicaid programs that would allow him to move into the community plainly fall within the disability discrimination condemned by the Supreme Court in *Olmstead*. The ADA and Section 504 clearly prohibit conditioning receipt of a public service or program on a person’s being institutionalized. That was the bedrock of the *Olmstead* decision. It also demonstrates Judge Ferguson’s conclusion that “[u]nderfunding of the Home and Community-Based Waiver program compels institutionalization, thus negating a meaningful choice.” *Cramer v. Chiles*, 33 F.Supp.2d 1342, 1353 (S.D. Fla.1999).

Due to his continuing institutionalization, Plaintiff Boyd is only taking two classes per semester rather than four, he must rely upon and pay others for transportation to and from the University in order to pursue his Master’s degree, he is unable to participate in various activities of the University, his opportunities for social activities are severely limited, his daily schedule is determined by the schedules of the staff and other

residents, his diet and eating schedule is determined by the facility, he has experienced more decubitus ulcers, he is subjected to noise, crying, odors, and exposed residents, he only receives \$30 from his Social Security Disability check of \$897, and he has no privacy. Due to Defendant's failure to provide services in the most integrated setting, he is forced to continue to relinquish independence to receive necessary services. Mr. Boyd's unjustified isolation triggers the primary concerns driving the Court in *Olmstead*, of (1) "perpetuat[ing] unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (2) "severely diminish[ing]" plaintiff's "everyday life activities...including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead*, 527 U.S. at 583. Forcing Mr. Boyd to receive services only in a nursing home setting continues to subject him to a very difficult environment, cut him off from community activities he enjoys including going to the movies with friends and going out at night, as well as adding difficulty, expense, and uncertainty to the pursuit of his educational goal that will lead to employment and full independence. (Exh. A, Amended Declaration of Mr. Boyd.)

Further, Defendant's requirement that Plaintiff Boyd remain in a nursing home instead of receiving services in the community violates the ADA in that Defendant may not condition receipt of community services on a person with a disability being in a segregated institution. Plaintiff Boyd is not required by law to stay in the nursing home to receive community-based services. Defendant's conditioning of community-based services on institutionalization is itself discrimination. In *Fisher v. Oklahoma Health Care Auth.*, 335 F. 3d 1175 (10th Cir. 2003), Oklahoma had changed its Medicaid

prescription program so that persons in the community would be entitled to receive no more than five prescriptions per month. However, if persons resided in a nursing facility, they could receive an unlimited number of prescriptions. The *Fisher* Court emphasized that “failure to provide Medicaid services in a community-based setting may constitute a form of discrimination.” *Id.* at 1182. The Tenth Circuit noted that the protections in the ADA’s “integration regulation,” 28 C.F.R. §35.130(d),

would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation. [W]hile it is true that plaintiffs in *Olmstead* were institutionalized at the time they brought their claim, nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA’s integration requirements.

Id. at 1181. *See also Radaszewski v. Maram*, 383 F.3d 599, 611 (7th Cir. 2004); *Long v. Benson*, No. 4: 08cv26, 2008 WL 4571903 (N.D. Fla. Oct. 14, 2008), *aff’d per curiam* 2010 WL 2500349 (11th Cir. June 22, 2010).

The same principle applies to Plaintiff Boyd. If he is forced to remain in a nursing home to receive services, he will be “unnecessarily institutionalized,” precisely the type of discrimination that Congress intended to end with the enactment of the ADA and Section 504. By requiring Plaintiff Boyd to remain in a nursing facility to receive necessary services, Defendant is conditioning the receipt of Mr. Boyd’s Medicaid services on living in an institutional setting (the nursing facility) which is segregated instead of providing services to Mr. Boyd in the community.

D. Defendant Violates the ADA and Section 504 by Failing to Make Reasonable Modifications and Accommodations in Her Policies, Practices, and Procedures

Section 504 and the ADA prohibit actions by covered entities that have a

discriminatory effect on people with disabilities. *See Alexander v. Choate*, 469 U.S. at 287 (1984); *Frederick L. v. Dep't of Public Welfare*, 364 F.3d 487 (3d Cir. 2004), 422 F.3d 151 (3d Cir. 2005). Both the ADA and Section 504 affirmatively require that covered entities make reasonable modifications and accommodations to their policies and practices when necessary to accommodate individuals with disabilities; *see Olmstead*, 527 U.S. at 592; *Alexander*, 469 U.S. at 301; and require that people with disabilities have “meaningful access” to covered entities’ programs. *Id.*; *Chaffin v. Kansas State Fair Bd.*, 348 F.3d 850, 857 (10th Cir. 2003); *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008) (Haynes, J.).

In the present action, Defendant’s failure to make reasonable modifications and accommodations results in Plaintiff Boyd’s being denied “meaningful access” to Medicaid waiver services in the community. Defendant has capped its waiver and has not increased it for a number of years to meet the needs of people on the wait list generally, including Mr. Boyd’s needs in the community. In *Olmstead*, the Supreme Court quoted the United States’ amicus brief that the Department of Health and Human Services “ ‘has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses’ .” *Olmstead*, 527 U.S. at 601.

Defendant has failed to grant Mr. Boyd’s requests for reasonable modifications to its waiver programs to allow him to receive the waiver services he needs in the community (ten hours per day of assistance with activities of daily living, assistance with his bowel program twice weekly, assistance with replacement of his catheter twice monthly and necessary equipment and care supplies). These modifications are easy to

accomplish and would result in a cost savings to Defendants. Yet, Defendant refuses to make the reasonable modifications in her programs that will ensure Mr. Boyd can live in the community and not suffer ongoing discrimination.

Beginning with *Southeastern Community College v. Davis*, 442 U.S. 397, 410 (1979), the courts have recognized that Section 504 requires publicly funded programs to provide reasonable modifications and accommodations when needed to assure that people with disabilities have meaningful access to programs and services. *See Alexander*, 469 U.S. at 300-01 & n.20-21. Title II of the ADA requires:

A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity.

28 C.F.R. § 35.130(b)(7) (authorized by 42 U.S.C. § 12134(b)).

The concept of reasonable modification recognizes that strictly “equal” treatment of people with disabilities will not assure meaningful access. *See Henrietta D. v. Bloomberg*, 331 F.3d 261, 273, 274-75 (2d Cir. 2003). Accordingly, the ADA and Section 504 require accommodations assuring that otherwise neutral policies and practices do not, in practice, discriminate against people with disabilities by denying them meaningful access to the covered entity’s programs and services. *Id.*, *see also US Airways, Inc. v. Barnett*, 535 U.S. 391, 397 (2002) (in ADA employment discrimination case, “preferences will sometimes prove necessary to achieve the Act’s basic equal opportunity goal”). For example, Section 504 and the ADA also prohibit discrimination on the basis of the severity of a person’s disability. In *Jackson v. Fort Stanton Hosp. & Training School*, 757 F. Supp. 1243 (D.N.M. 1990), *rev’d on other grounds*, 964 F.2d

980 (10th Cir. 1992), plaintiffs with developmental disabilities challenged their exclusion from the state's community services program because of the severity of their disabilities. In that case, people with severe disabilities were precluded from living in community settings because the programs lacked amenities that reasonably could be furnished that were necessary to accommodate plaintiffs' serious needs. The court found that "Defendants' failure to accommodate the severely handicapped in existing community programs while serving less severely handicapped peers is unreasonable and discriminatory." *Id.* at 1299. It concluded that:

modification of the existing community service system in New Mexico would not require an excessive financial burden and that the accommodations would enable severely handicapped residents of [residential facilities] to realize the benefits of community settings. Accordingly, the defendants should require those community programs that receive federal assistance funds to make reasonable accommodations for those severely handicapped residents [of facilities] whose IDTs have determined that a community program could be appropriate, if reasonably modified.

Id. at 1299. *See also Williams v. Wasserman*, 937 F. Supp. 524, 530 (D. Md. 1996) ("... while the ADA does not place an affirmative obligation on the state to create or fundamentally alter a program of community-based treatment options, the ADA does oblige the defendant to make those options available to otherwise qualified individuals without regard to the severity ... of their disabilities."); *Martin v. Voinovich*, 840 F. Supp. 1175, 1192 (S.D. Ohio 1993) ("Defendants' failure to accommodate the severely handicapped in existing community programs while serving less severely handicapped peers is unreasonable and discriminatory.").

A recent reasonable accommodation case from the Seventh Circuit is quite instructive. In *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004), plaintiff sought 24-

hour private duty nursing care under the HCBS waiver program, a service he alleged he would require in a hospital or nursing facility if forced to move there. The State argued that it did not provide that level of service under its waiver, and that plaintiff could only receive \$4,593 per month - the equivalent of five hours a day of private-duty nursing care. However, the court found that the state already provided for some private duty nursing care, and further that,

the integration mandate may well require the State to make reasonable modifications to the form of existing services in order to adapt them to community-integrated settings.... If variations in the way services were delivered in different settings [home vs. institution, or assisted living facility vs. an apartment] were enough to defeat a demand for more community integrated care, then the integration mandate of the ADA and the Rehabilitation Act would mean very little.

Id. at 611.

On remand, the district court found that the state's failure to fully fund at home private duty nursing for the young man under the Medicaid-funded HCBS constituted disability discrimination, and that the state was obligated to provide treatment in the most integrated setting - his home. It rejected the state's claim that such an outcome would result in a fundamental alteration of the state's program. *Radaszewski v. Maram*, 2008 WL 2097382, *15 (N.D. Ill., March 26, 2008); *see also Grooms v. Maram* 2008 WL 2271492, *16 (N.D. Ill., May 30, 2008); *Long v. Benson*, No. 4: 08cv26, 2008 WL 4571903 (N.D. Fla. Oct. 14, 2008), *aff'd per curiam* 2010 WL 2500349 (11th Cir. June 22, 2010); *Disability Advocates Inc. v. Paterson*, 598 F.Supp.2d 289 (E.D.N.Y. 2009).

In nursing homes across Alabama and under its different community-based waiver programs Defendant already provides the kind of services Mr. Boyd requires. (Exh. D, Alabama Medicaid chart on waiver programs.) If any modification of

Defendant's services is required, Defendant need only make modest modifications to provide Mr. Boyd with the services he needs in the community rather than forcing him to be institutionalized in a nursing home.

E. Plaintiff Boyd's Requests for Modifications Are Reasonable

It is well-established that the ADA and Section 504 both require Defendant to make reasonable modifications and accommodations to her policies, practices, and procedures when necessary to avoid discrimination. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b)(7) (ADA). In a reasonable accommodation and modification claim, the plaintiff has the obligation to articulate a modification that "seems reasonable on its face." *US Airways, Inc. v. Barnett*, 535 U.S. 391, 401 (2002); *see also Skerski v. Time Warner Cable Co.*, 257 F.3d 273, 284 (3d Cir. 2001) ("... plaintiff bears only the burden of identifying an accommodation, the costs of which do not clearly exceed its benefits," *i.e.*, that is not "clearly ineffectively or outlandishly costly."). If the plaintiff articulates a reasonable modification, then the burden shifts to the defendant to prove that the proposed modification would impose an undue burden on its resources or a fundamental alteration of its program. *Olmstead*, 527 U.S. at 603; *Frederick L.*, 364 F.3d at 492 n.4.

Defendant has ignored her obligation to Plaintiff Boyd by not providing him waiver services. Defendant operates a Medicaid waiver program that permits Defendant to provide home and community based services to a person who otherwise would require nursing home level care. *See* 42 U.S.C. § 1396n(c)(1) ("but for the provision of such [waiver] services the individuals would require the level of care provided in ... a nursing facility... the cost of which would be reimbursed under the State plan"). When CMS approved Defendant's Medicaid waiver program, Defendant took on the mandatory

obligation to provide such in-home care to qualifying individuals such as Plaintiff Boyd. Under Defendant's Medicaid waiver program Defendant had, and has, the ability to provide Boyd with home and community based services in lieu of nursing home care.

Courts have held that increasing expenditures and increasing the numbers of people who receive waiver services in the community is not an unreasonable accommodation. *See e.g., Radaszewski*, 383 F.3d at 613-15; *Frederick L. v. Dep't of Public Welfare*, 364 F.3d 487, 500 (3rd Cir. 2004); *Fisher*, 335 F. 3d at 1182-83; *Makin v. Hawaii*, 114, F. Supp. 2d 1017, 1034 (D. Haw. 1999).

The reasonableness of a particular accommodation "depends on the individual circumstances of each case" and "requires a fact-specific, individualized analysis of the disabled individual's circumstances and accommodations that might allow her to meet the program's standards." *Wong v. Regents of the Univ. of Cal.*, 192 F.3d 807, 818 (9th Cir. 1999).

Plaintiff Boyd has identified the services and program modifications he seeks. Nearly two years ago he asked Defendant to provide community services and he recently renewed that request for services through his attorneys. Instead of complying, Defendant continues to pay for Boyd's services only in a nursing home. Under the federal requirements for a waiver, a state must assure the federal agency that in the aggregate the waiver is "cost effective," that is, on the average, the amount spent on community-based services "will not exceed the amount of such medical assistance provided for such individual [in the nursing facility] if the waiver did not apply." 42 USC § 1396n(c)(4)(A). The reasonable modifications requested by Plaintiff Boyd fall squarely within Defendant's clearly existing duties under federal law.

IV. Irreparable Injury

Mr. Boyd, having been accepted into his graduate program at the University of Montevallo, began his graduate coursework in September 2010. However, due to his situation: he is only taking two classes per semester instead of four; he is being forced to rely upon and pay a nursing home maintenance worker his entire scholarship award (\$500 for the semester) to transport him to and from the campus for his classes for this semester; he is being forced to rely upon and pay others \$20 per trip (borrowed from his brother) to transport him to and from the campus on six occasions this semester in order to complete required assignments and; he is prevented from engaging in other University activities, such as attending athletic events, author readings, theatrical performances, and musical performances. Such injuries are ongoing and irreparable. (Exh. A, Amended Declaration of Mr. Boyd.)

Mr. Boyd must also await action by Defendant in order to move forward with securing accessible housing he has located near campus, which will be available for occupancy in January 2011, in time for the beginning of his next semester. He needs to secure this housing as soon as possible because accessible housing is difficult to locate and secure and he may be prevented from securing alternate housing otherwise. (Exh. A, Amended Declaration of Mr. Boyd.)

Mr. Boyd's quality of life is greatly affected by living in the nursing home. He has experienced more decubitus ulcers (pressure sores). His daily care schedule is determined by the schedules of staff and other patients. His diet and eating schedule is determined by the staff. He is subjected to noise, crying, odors, and exposed residents. Most other residents are much older than he is. The social activities are not geared to

persons his age. His social life is greatly impaired. He only receives \$30 of his Social Security Check of \$897. He has no privacy. These injuries are ongoing and irreparable as well. (Exh. A, Amended Declaration of Mr. Boyd.)

Additionally, Courts have recognized irreparable injury specifically as a result of institutionalization in a nursing facility. *See Long v. Benson*, No. 4: 08cv26, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008), *aff'd per curiam* 2010 WL 2500349 (11th Cir. June 22, 2010).

The emotional impact of institutionalization has been noted by courts: "... this will inflict an enormous psychological blow. Also, because of the very substantial difference in [plaintiff's] perceived quality of life in the apartment as compared to the nursing home, each day he is required to live in the nursing home will be an irreparable harm." *Long v. Benson* at *2.

The detrimental effects of institutionalization have been recognized similarly in another ADA case where the court noted: "... forcing these Plaintiffs into nursing homes that would be detrimental to their care, causing, *inter alia*, mental depression, and for some Plaintiffs, a shorter life expectancy or death." *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008).

If a preliminary injunction is not issued, Mr. Boyd will continue to suffer irreparable injury. He has no option other than to stay in the nursing home and continue to suffer a range of injuries such as those described in *Olmstead*. Such discrimination and irreparable injury are unnecessary if the Defendant would only authorize Mr. Boyd's receipt of necessary services in the community. Boyd's irreparable injury includes more than a violation of his civil rights under the ADA and Section 504. Mr. Boyd continues

to suffer irreparable injury through segregation and institutionalization in a setting that demeans him by taking away his independence and dignity.

V. Balance of Hardships

The Court must weigh the harm to Plaintiff Boyd against possible damage to Defendant. *Long v. Benson*, No. 4: 08cv26, 2008 WL 4571903, at*3 (N.D. Fla. Oct. 14, 2008), *aff'd per curiam* 2010 WL 2500349 (11th Cir. June 22, 2010); *All Care Nursing Serv., Inc., v. Bethesda Memorial Hosp., Inc.*, 887 F.2d 1535, 1537 (11th Cir. 1989). While Plaintiff Boyd is threatened with continued institutionalization, Defendant's only possible damages are monetary. The harm to Plaintiff Boyd clearly outweighs any harm to Defendant. *See, e.g., Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) (harm to plaintiffs of being deprived of essential medical services outweighs any harm to state); *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 371 (N.D. Ill. 1983) ("... *once* a state has voluntarily elected to participate in the Medicaid program ... [it cannot] characterize its duty to comply with the requirements of [the program] as constituting a hardship to its citizens."); *Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1548, 1552-53 (D. Kan. 1993) (threatened injuries to plaintiffs outweighed any harm to defendant that would result from issuing the temporary restraining order because changing Medicaid coverage "significantly alters the status quo to the detriment of the individual plaintiffs, while its positive budgetary impact on state coffers is negligible in a relative sense.").

The balance of hardships clearly favors Mr. Boyd. He asks simply that the Defendant permit him to reside in the community with the Medicaid waiver services he needs rather than being confined in a nursing home as a precondition to receipt of the

same or similar services.

VI. The Public Interest

A preliminary injunction requiring Defendant to provide services to Mr. Boyd to avoid institutionalization is not adverse to the public interest. In determining whether the public interest will be disserved by the granting of a request for preliminary injunction, courts may look to the legislative intent in enacting the statute sought to be enforced. As the Eleventh Circuit found in *Johnson v. U.S.D.A.*, 734 F.2d 774, 788 (11th Cir. 1984), cost to the government “alone” is not a reason to deny a preliminary injunction as being against the public interest. In a case challenging foreclosure procedures, the court looked at the legislative purposes of the Housing Act of 1949 and found that the public interest of providing decent housing would be served by preventing premature foreclosures. *Id.*

The public interest also will be served by an order granting a preliminary injunction for Mr. Boyd. A strong public policy is unambiguously expressed in the ADA and Section 504. Congress found that discrimination against people with disabilities is a serious and pervasive social problem, and that people with disabilities have been subjected to a history of purposeful unequal treatment and relegated to a position of political powerlessness based on characteristics that are beyond the control of such individuals and resulting from stereotypical assumptions not truly indicative of the individual ability of such persons to participate in and contribute to society. 42 U.S.C. §12101. The purpose of the ADA’s passage was to provide a clear and comprehensive national mandate for elimination of discrimination against individuals with disabilities. Accordingly, the public interest will be served by issuance of the requested preliminary injunctive relief.

VII. Waiving the Bond Requirement

Plaintiff receives only \$30 per month from his Social Security Disability benefits for personal spending. (Exh. A, Amended Declaration of Mr. Boyd.) Plaintiff should be exempted from the bond requirement of Fed. R. Civ. P.65(c). *See Long v. Benson*, No. 4: 08cv26, 2008 WL 4571903, at *3 (N.D. Fla. Oct. 14, 2008), *aff'd per curiam* 2010 WL 2500349 (11th Cir. June 22, 2010) (court holding in part that indigent plaintiff ought not be required to post security as a condition of the preliminary injunction). The amount of required security is within the discretion of the trial court. *Caterpillar, Inc. v. Nationwide Equipment*, 877 F.Supp. 611, 617 (M.D. Fla. 1994); *Baldree v. Cargill, Inc.*, 758 F.Supp. 704, 708 (M.D. Fla. 1990). The court may also waive all payment.

Courts have used their discretion to waive the bond requirement for indigent plaintiffs. *E.g., Bass v. Richardson*, 338 F. Supp. 478, 490 (S.D.N.Y. 1971) ("It is clear that indigents, suing individually or as class plaintiffs, ordinarily should not be required to post a bond under Rule 65(c)."); *Denny v. Health & Social Serv. Bd. of State of Wis.*, 285 F. Supp. 526, 527 (E.D. Wis. 1968) ("Poor persons ... are by hypothesis unable to furnish security as contemplated in Rule 65(c), and the court should order no security in connection with the preliminary injunction."). *See also Maine Ass'n of Interdependent Neighborhoods*, 647 F. Supp. 1312, 1319 (D.Me. 1986) (court granted waiver of bond, noting impecunious status of plaintiffs, and based on plaintiff's strong case on the merits).

Plaintiff Boyd is indigent and seeks injunctive relief to receive services in the community of the kind that Defendant already provides in nursing homes across Alabama and through its different waiver programs. This case implicates the public interest. The balance of hardships tips sharply in favor of the Plaintiff. This Court should not require

Plaintiff Boyd to give security.

VIII. Conclusion

For the reasons and on the authority cited above, Plaintiff Boyd respectfully requests that this Honorable Court grant him preliminary injunctive relief. He has demonstrated that he has a substantial likelihood of success on the merits; he will suffer irreparable injury if emergency relief is denied; and the balance of hardships tips in his favor.

Respectfully Submitted,

s/Lonnie J. Williams

Lonnie J. Williams (ASB-2866-I35W)
E-mail: lwilliams@adap.ua.edu
Alabama Disabilities Advocacy Program
Box 870395
Tuscaloosa, AL 35487-0395
Telephone: (205)348-4928
Facsimile: (205)348-3909

James A. Tucker (ASB-6986-T39J)
E-mail: jtucker@adap.ua.edu
Alabama Disabilities Advocacy Program
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Stephen F. Gold (PA Bar No. 09880)
Email: stevegoldada@cs.com
1709 Benjamin Franklin Parkway
Second Floor,
Philadelphia, PA 19103
Telephone: (215)627-7100, ext. 227
Facsimile: (215)627-3183

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

This is to certify that on the 29th day of September, 2010, a copy of the foregoing has been electronically filed with the Clerk of the Court using the CM/ECF system, which will electronically send a copy of the same to the following: Stephanie McGee Azar (stephanie.azar@medicaid.alabama.gov), Margaret L. Fleming (mfleming@ago.state.al.us), James W. Davis (jimdavis@ago.state.al.us), and Misty S. Fairbanks (mfairbanks@ago.state.al.us).

s/Lonnie J. Williams
Lonnie J. Williams

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA**

JONATHAN PAUL BOYD,

Plaintiff,

v.

Case No.: 2:10cv688-TFM

CAROL A. HERRMANN-STECKEL,
In her official capacity as Commissioner of
Alabama Medicaid Agency,

Defendant.

AMENDED DECLARATION OF JONATHAN PAUL BOYD

I, Jonathan Paul Boyd, hereby declare the following statements are true and correct, to the best of my information, knowledge, and belief.

1. I am an Alabama resident. I have tetraplegia as a result of an accident. I am eligible for and receive Medicaid. For eleven years after my accident, I lived in the community with my family until they could no longer provide adequate informal support. I desire to reside in the community instead of in a nursing facility where I have resided for more than three years. I could reside in the community with appropriate services provided with Medicaid funds, but I am unnecessarily institutionalized because Defendant will not provide me with appropriate services in the community.
2. I was born on January 20, 1976 and I am thirty-four years old.
3. In 1995, when I was a nineteen-year-old sophomore student at Troy State University, I was in an accident, falling off a balcony in my home. I broke my spine as a result of the accident and I am paralyzed below my collar bone. I cannot use my arms or legs.
4. After months of hospitalization in the Lakeshore Rehabilitation Center in Birmingham, I

returned home and lived with my mother, stepfather, and sister. For eleven years after my accident I lived at home with my mother and stepfather. My mother was my primary caregiver.

5. When I lived at home with my mother, I was eligible for and received some community-based Medicaid waiver services to complement the care my mother provided. In December 2006, I had to enter a nursing home because my mother could no longer provide the care I required to supplement the waiver services which were insufficient without family informal support. These Medicaid waiver services were discontinued when I had to enter the nursing facility. I am eligible for and receive Medicaid which pays for my nursing home services.
6. I use a motorized wheelchair for ambulation, which I control and direct with a "sip and puff" device.
7. In the nursing home, I receive assistance with my activities of daily living, such as taking medication, bathing, dressing, toileting, feeding, transferring from and to my bed and into and out of my wheelchair. I also receive assistance with some basic household chores. I receive assistance with my bowel program twice per week and assistance with changing my catheter twice per month.
8. In order to live in the community, I need community-based Medicaid services including ten hours per day of assistance with activities of daily living, assistance with my bowel program twice per week, assistance with changing my catheter twice per month and necessary equipment and care supplies.
9. These services could be provided by the Defendant's Medicaid program through a waiver, a combination of waivers, or reasonable modifications of waivers.

10. Eventually after my accident, I returned to college and graduated in 2007 from the University of Montevallo with a bachelor of fine arts degree. In college, I organized several programs, including one to feed low-income persons at Christmas, an accessibility program to raise funds to help make businesses accessible, and, as a member of Pi Kappa Alpha, I organized other community services.
11. Earlier this year, I was accepted to a graduate program at the University of Montevallo to seek my master's degree in community counseling. I began that program in September 2010.
12. My nursing facility is 13 miles from the University. While living at the nursing home and attending classes for my undergraduate degree, I was able to use public transportation (ClasTran) to travel between the nursing home and the campus. My undergraduate classes were day classes and public transportation, though terribly inconsistent, was adequate. However, public transportation ends at 3:30 p.m. and my graduate studies classes are only offered at night.
13. The two classes I am currently taking are from 5 p.m. to 8 p.m. on Monday and Tuesday. I am forced to rely upon and pay a nursing home maintenance worker my entire scholarship award (\$500 for the semester) to provide me with transportation to and from campus for the semester in order to attend those classes.
14. I also have to travel to campus on six other occasions this semester in order to complete required assignments. I am forced to rely upon and pay others \$20 per trip to transport me to and from campus for those required assignments. My brother is currently lending me the money to pay for these trips to campus for required assignments.

15. Because I live in the nursing home, rather than living in the community near campus as I prefer, I cannot travel to campus readily and independently. For this reason, I am taking only two classes this semester rather than four classes and I am not attending other University functions that I would like to attend (such as athletic events, author readings, theatrical performances, and musical performances).
16. Due to my present living situation, I am experiencing increased time, difficulty, and expense required for me to earn my graduate degree and I am being prevented from participating in several aspects of college life that other graduate students enjoy.
17. I have located rental housing near the University of Montevallo which would suit my accessibility needs and would allow me to travel to and from campus readily and independently. This housing will be available for occupancy in January 2011, in time for the beginning of my next semester of graduate school. In order to move forward with my plans to secure rental of this housing, I need to know that I will have appropriate services in the community at that time. Accessible rental housing is difficult to locate and secure, so I need to secure this housing as soon as possible.
18. With my master's degree, I want to work and to establish a foundation for people with disabilities to obtain technology to assist them in school or at work. I wish to leave the nursing facility to live in the community and to receive services near the University so I can readily and independently travel to classes, assignments, and other University activities.
19. Throughout the eleven years I resided at home, between the time of my accident and when I moved into a nursing facility, I had only one decubitus ulcer (pressure sore). Since December 2006 when I moved into a nursing facility, I have had five.

20. I visit my family and friends as often as I can. I also try to eat out of the nursing home with friends and join them at the movies. As a resident of the nursing home I must, however, return to the facility by a specific time in the evening, which limits my socializing with friends and having overnight stays with friends. As a Medicaid resident in the nursing home, I receive only \$30 of my monthly Social Security Disability check of \$897. With such limited financial resources, I am extremely limited in going to the movies, eating out, or having snacks.
21. In the nursing home, all the residents are disabled and most are much older than me. Living in a nursing home I am deprived of the simple pleasure of being around people my own age and with similar interests and activities. I do not take part in the activities that the nursing home's activities department puts on multiple times daily because they are geared towards octogenarians. Since I have been a resident in the nursing home, I have taken part in a half dozen activities and they centered around meals or ice cream.
22. There is no privacy in the nursing facility. People come and go as they like, and there is constant noise and people screaming. Residents in the nursing facility are often not dressed, exposed, and constantly crying. There is also a pervasive unpleasant disinfectant odor.
23. I do not want to live in a nursing home; instead, I want to reside in the community, where I can have an active life. Without community-based Medicaid waiver services, I will continue to be unnecessarily institutionalized, even though I desperately do not want to reside in a nursing facility.
24. Despite Defendant knowing that I have been unnecessarily institutionalized for more than three years, she has not offered me the Medicaid services necessary to allow me to reside

in the community. I applied for Alabama's Medicaid community-based waiver program in October 2008 and have been on the waiting list for services since that time. My attorneys recently renewed my request for services by asking the Defendant to make reasonable modifications to its waiver programs and provide me with waiver services including ten hours per day of assistance with activities of daily living, assistance with my bowel program twice per week, assistance with changing my catheter twice per month and necessary equipment and care supplies. That request was not granted.

25. To obtain necessary services, Defendant requires that I continue to reside in a Medicaid-funded nursing facility setting. Defendant's Medicaid program will only provide the services I require by paying for my institutionalization in a nursing facility.
26. I have no option other than to remain in a nursing home where Defendant's Medicaid program will pay for the same services I could receive in the community.

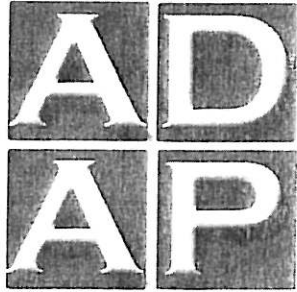
Under penalty of perjury, I declare these statements as true and correct to the best of my information, knowledge, and belief.

Executed by Jonathan Paul Boyd on this the 29th day of September, 2010.


Jonathan Paul Boyd

Witness by  (Joe Meadows)
Unable to sign due to disability.

ALABAMA DISABILITIES



ADVOCACY PROGRAM

July 12, 2010

VIA FACSIMILE COPY AND U.S. MAIL

334-353-3907

Mr. William O. Butler, II, Esq.
Alabama Medicaid Agency
P.O. Box 5624
Montgomery, AL 36103-5624

RE: Jonathan Paul Boyd

Bill

Dear Mr. Butler:

Protection & Advocacy for
Persons with Developmental
Disabilities

Protection & Advocacy for
Individuals with Mental Illness

Protection & Advocacy of
Individual Rights

Protection & Advocacy for
Assistive Technology

Protection & Advocacy for
Individuals with
Traumatic Brain Injury

Protection & Advocacy for
Beneficiaries of Social Security

Protection & Advocacy for
Voting Accessibility

THE UNIVERSITY OF
ALABAMA
FOUNDED 1831

We write on behalf of Mr. Boyd who receives Medicaid, has been in a nursing facility for three years, and wishes to return to the community where he lived for 11 years after he became disabled.

Mr. Boyd was a college student when he was injured in an accident in 1995. He broke his spine, was paralyzed below his collarbone and, as a result, cannot use his arms or legs.

After rehabilitation Mr. Boyd returned home where he lived with his family and received some community-based Medicaid waiver services. When his family no longer could provide the care he needed and he could not obtain waiver services to remain in the community, Mr. Boyd was forced to enter a nursing facility in December 2006.

Mr. Boyd uses a motorized wheelchair and requires assistance with activities of daily living and some basic household chores. To obtain such assistance outside the nursing facility, Mr. Boyd applied for Medicaid's community-based waiver program (i.e., services like those he received when he lived at home) in 2008. He has been on a waiting list for such services for nearly two years.

Until recently, Mr. Boyd attempted to communicate with your Agency through the assistance of others. ADAP now represents Mr. Boyd.

I urge you to review this matter. Mr. Boyd is an extraordinarily accomplished person. Despite numerous challenges, he graduated from Montevallo in 2007. He has been accepted to Montevallo's graduate school to seek his master's degree beginning this fall. Mr. Boyd wishes with all his heart to leave the nursing facility before beginning his master's program so he can live on or near campus and more easily attend classes and participate in college life as a graduate student.

500 Martha Parham West
Box 870395
Tuscaloosa, Alabama 35487-0395
(205)348-4928
(800)826-1675
FAX (205)348-3909
adap@adap.ua.edu
www.ADAP.net

As Mr. Boyd's counsel, we are firmly convinced Mr. Boyd has been unnecessarily institutionalized for more than three years in violation of the ADA, the Rehab Act, and the Supreme Court's guidance provided in Olmstead:

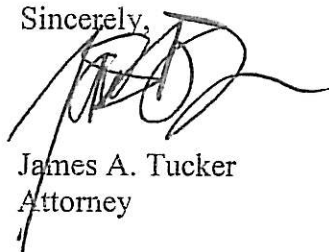
- ▶ Mr. Boyd should have been provided with community-based Medicaid waiver services, like those he received while at his family home, when he sought them to avoid institutionalization.
- ▶ Mr. Boyd should not have had to enter the nursing facility to begin with.
- ▶ Mr. Boyd should be able to receive in the community services akin to those he receives in the nursing facility.
- ▶ Mr. Boyd should have been able to obtain the waiver services he sought at some point while he lingered on the waiting list.

We look forward to hearing from you at your earliest convenience. We hope we can resolve this matter expeditiously so Mr. Boyd can resume a far fuller life in the community, including pursuing his graduate degree this fall.

If we do not hear from you on or before Monday, July 19, 2010, we will file suit to pursue appropriate remedies for Mr. Boyd.

Thank you for your attention to this matter.

Sincerely,

A handwritten signature in black ink, appearing to be 'JAT', written over a horizontal line.

James A. Tucker
Attorney

Cc: Mr. Paul Boyd
Lonnie Williams, Esq.
Steve Gold, Esq.

Williams, Lonnie

From: Williams, Lonnie
Sent: Monday, August 09, 2010 9:28 AM
To: 'Margaret Fleming'
Cc: Tucker, James; SteveGoldADA@cs.com; 'stephanie.azar@medicaid.alabama.gov'
Subject: RE: ADAP and JPB

Margaret,

Time is of the essence, because Mr. Boyd wants to start attending school at the latter part of August.

Point blank: Will Alabama agree to, under any of its programs, make reasonable accommodation for Mr. Boyd to provide 10 hours a day and necessary equipment?

It's a "yes" or "no" question. If the answer isn't "yes" by end of business today, we will have no choice but to take immediate legal action.

Sincerely,

Lonnie Williams
ADAP

-----Original Message-----

From: Margaret Fleming [mailto:megfleming@charter.net]
Sent: Friday, August 06, 2010 4:10 PM
To: Williams, Lonnie
Cc: stephanie.azar@medicaid.alabama.gov; SteveGoldADA@cs.com; Tucker, James; 'Fleming, Margaret'; jimdavis@ago.state.al.us; 'Fairbanks, Misty'; wparker@ago.state.al.us
Subject: RE: ADAP and JPB

Lonnie,

It is my understanding that Medicaid waiver programs are, by federal law, mutually exclusive; therefore your suggestion that we try to meet all of Mr. Boyd's demands through a combination of waiver programs is not practical. Each program is different, and must stand on its own. Our mission, as we understood it, was to determine whether this litigation might settle within the parameters of the existing "policies, practices and programs" of the Alabama Medicaid Agency. If I am wrong, please correct me, for in that event, I am wasting our time.

For what it is worth, my email below was not a "final offer", but rather the fruits of our initial effort to determine whether an existing waiver program might possibly work for Mr. Boyd. It seems from your response that Mr. Boyd is not interested in the SAIL waiver program as it now exists, primarily due to the limitation in the number of hours of personal care that would be reimbursable under that program. Is that correct?

Very truly yours,

Margaret L. Fleming

-----Original Message-----

From: Williams, Lonnie [mailto:lwiliams@adap.ua.edu]
Sent: Friday, August 06, 2010 11:34 AM
To: Fleming, Margaret
Cc: stephanie.azar@medicaid.alabama.gov; SteveGoldADA@cs.com; Tucker, James
Subject: RE: ADAP and JPB

Margaret,

You asked whether Mr. Boyd is interested in the SAIL waiver program. Mr. Boyd is interested in having Alabama Medicaid end his segregation and institutionalization by whatever means can reasonably be made available, whether through one waiver program, a combination of waiver programs, reasonable modifications thereof, or programs that don't yet exist but can be developed for Mr. Boyd. Per your request, we did our best to identify, based upon our present understanding, what Mr. Boyd needs from you in order to transition to the community. We find your offer to be inadequate. The \$12,000 available for equipment is something that we might could work around. But what you are offering as far as services for his care is insufficient. (In our prior email, we did mean 10 hours per day, 7 days a week, by the way.) As far as services for his care, you have simply listed what is available under the SAIL waiver program as it currently exists.

Other than presumably placing Mr. Boyd at the head of a waiting list, you have made no attempt to offer Mr. Boyd a reasonable modification of your policies, practices and programs to provide him with the care services he would need in the community. We request that you do so. Does your final offer consist of your email below? We look forward to your response by the end of business today.

Sincerely,

Lonnie J. Williams
ADAP

-----Original Message-----

From: Fleming, Margaret [mailto:MFleming@ago.state.al.us]
Sent: Wednesday, August 04, 2010 4:20 PM
To: Williams, Lonnie; Tucker, James; SteveGoldADA@cs.com
Cc: stephanie.azar@medicaid.alabama.gov; Davis, Jim; Fairbanks, Misty; Parker, Will
Subject: RE: ADAP and JPB

Counsel:

Thank you for your email yesterday evening. We welcome the opportunity to resolve this matter without litigation.

After some investigation, it was determined that before entering Chandler Health & Rehab Center, Mr. Boyd participated in the Medicaid SAIL waiver program. Under that program, Mr. Boyd would again be responsible for securing a place to live, and designating a responsible adult who would agree to serve as his primary caregiver without compensation.

There are limitations on the equipment and services that are reimbursable under the SAIL waiver program which appear to exceed, substantially, the needs you have identified. First, participants are limited to 25 hours per week of personal care services; you have requested 10 hours per day - presumably 7 days a week, but that is not clear from your email. Second, there is a \$15,000 total limitation on expenditures for equipment. Medicaid has already provided reimbursement for some expenditures for equipment under the SAIL waiver program for Mr. Boyd, and so approximately \$12,000 would remain available to him.

The aggregate cost of the items you identified in you email far exceed that dollar limit. Finally, no skilled nursing services are available under the SAIL waiver program. You have identified needs that appear to go beyond what a personal care assistant could legally

provide in Alabama, such as daily assistance with medications, catheter and bowel program assistance, and wound inspection and care.

Within these limitations, please confirm to us whether Mr. Boyd is interested in the SAIL waiver program.

Very truly yours,

Margaret Fleming

-----Original Message-----

From: Williams, Lonnie [mailto:lwilliams@adap.ua.edu]

Sent: Tuesday, August 03, 2010 5:03 PM

To: stephanie.azar@medicaid.alabama.gov; Fleming, Margaret

Cc: Tucker, James; SteveGoldADA@cs.com

Subject: ADAP and JPB

RE: Jonathan Paul Boyd

Stephanie and Margaret,

I forgot to list one more item. Mr. Boyd also needs a nebulizer. I'm sorry for leaving that out of my last email.

Sincerely,

Lonnie J. Williams

Alabama Disabilities Advocacy Program

No virus found in this incoming message.

Checked by AVG - www.avg.com

Version: 9.0.851 / Virus Database: 271.1.1/3054 - Release Date: 08/06/10

02:37:00

Williams, Lonnie

From: Williams, Lonnie
Sent: Tuesday, August 03, 2010 4:45 PM
To: stephanie.azar@medicaid.alabama.gov; mfleming@ago.state.al.us
Cc: Tucker, James; SteveGoldADA@cs.com
Subject: ADAP and JPB

RE: Jonathan Paul Boyd

Stephanie and Margaret,

Thank you for speaking with us by phone today and for requesting further information about Mr. Boyd's needs.

With the caveat that we understand that Medicaid should do a "needs assessment" and work jointly with the discharge planner at Chandler Health and Rehabilitation to develop and implement a "discharge plan" and "care plan" for Mr. Boyd, we are providing information concerning what we know about Mr. Boyd's transition needs at this time.

Mr. Boyd needs the following:

-Ten hours of assistance per day (for activities of daily living, operating a lift for transfers, changing bed pads, giving medication, etc.)

-Nursing assistance once every two weeks for changing his catheter.

-Nursing assistance twice per week for his bowel program.

-A bed/mattress that turns him. Preferably a Stryker XPRT. But, in the alternative, an Invacare microAIR.

<http://www.stryker.com/en-us/products/PatientHandlingEMSandEvacuationEquipment/Surfaces/XPRTAdvancedPulmonaryTherapy/index.htm>

http://www.invacare.com/cgi-bin/imhqprd/inv_catalog/prod_cat_detail.jsp?s=0&prodID=BB9612000

-An environmental control unit to allow him to operate his telephone, television, bed, and other electronics in his home, along with an attachment for the unit to make it mobile so Mr. Boyd can operate the unit from his wheelchair. Preferably Imperium products. But in the alternative, the Tash Sicare Pilot.

<http://www.assistivetechologies.com/detail.asp?productId=54377>

<http://www.assistivetechologies.com/detail.asp?productId=54397>

http://www.x10.com/promotions/am466_4f3_si.html

http://www.remposs.com/catalog.php?prod_cat=PC&item_type=ECP&item_id=ti_sicare

-An automatic door opener that Mr. Boyd can operate from his wheelchair. Preferably from Open Sesame Door Systems.

<http://www.opensesamedoor.com/>

-A Hoyer Heavy Duty Power Patient lift with cloth sling for transfers between the bed and wheelchair.

http://www.patientliftdeals.com/Hoyer_Heavy_Duty_Patient_Lift/p/39914/c/56/

-Supplies including lotion, soap, ointment, two disposable pads per night, one 60cc syringe per day, and three catheters per month (see: <http://www.ambercity.com/coude-foley-catheter-foley-catheters-dynd11218h.html> for the specific type of catheters).

We believe most of the durable medical equipment and assistive technology listed above is available through QuadAdapt, an approved provider in Spanish Fort, Alabama.

<http://www.quadadapt.com/home.html>

We look forward to your reply by the end of business on Wednesday, August 4, 2010, as we previously discussed.

Please know that we are happy to meet with Medicaid or designated staff and Mr. Boyd to facilitate his contemplate transition to the community.

Sincerely,

Lonnie J. Williams

Alabama Disabilities Advocacy Program

ALABAMA HOME AND COMMUNITY-BASED WAIVER SERVICES

Medicaid is a health care program for low income Alabamians. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria. This chart summarizes those benefits and criteria, and tells you how to apply for Medicaid under a waiver. For some people, a waiver is the only way to qualify for Medicaid. Additional information can be found at the Alabama Medicaid Agency's website: www.medicaid.alabama.gov

Clients must meet financial, medical, and program criteria to access waiver services. The applicant must also be at risk of nursing institutionalization (nursing facility, hospital, ICF/MR). Clients in a waiver program must be willing to receive services in their homes or communities. A client who receives services through a waiver program also is eligible for all basic Medicaid covered services. When a client chooses to receive waiver services, the services must be provided by certified Medicaid providers. The cost of waiver services cannot be more than the cost of the level of care the waiver is based upon.

Each waiver program has an enrollment limit. There may be a waiting period for any particular waiver. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time. Anyone who is denied Medicaid eligibility for any reason has a right to appeal. Talk to your county or regional certifying agency if you wish to exercise your right to appeal.

	Elderly & Disabled Waiver (Since 1982)	Intellectual Disabilities Waiver (Since 1981)	Living at Home Waiver (Since 2002)	State of Alabama Independent Living Waiver (Since 1992)	HIV/AIDS Waiver A.K.A. 530 Waiver (Since 2003)	Technology Assisted Waiver for Adults (Since 2003)
What is the purpose?	To provide services that would allow elderly and/or disabled individuals to live in the community who would otherwise require nursing facility level of care	To provide service to individuals that would otherwise require the level of care available in an intermediate care facility for the mentally retarded	To provide services to individuals who would otherwise require the level of care available in an ICF/MR	To provide services to disabled adults with specific medical diagnoses** who meet the nursing facility level of care criteria	To provide services to individuals with a diagnosis of HIV, AIDS, and related illness who would meet the nursing facility level of care criteria	To provide services to individuals who received private duty nursing services, through the EPSDT Program under the Medicaid State Plan who will no longer be eligible for the service upon turning age 21
What is the target population?	Individuals meeting the Nursing Facility Level of Care	Individuals with a diagnosis of Mental Retardation (MR); Individuals meeting an Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Individuals with a diagnosis of Mental Retardation (MR); Individuals meeting the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care; Persons not residing in a group home setting or environment; Persons currently on the waiting list for MR services	Individuals with a specific medical diagnoses	Individuals with a diagnosis of HIV or AIDS and related illnesses.	Individuals who received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning age 21 and for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria.
What are the services provided?	- Case Management - Homemaker Services - Personal Care - Adult Day Health - Respite Care (Skilled and Unskilled) - Adult Companion Services - Home Delivered Meals	- Residential Habilitation - Residential Habilitation - Other Living Arrangement - Day Habilitation - Level 1-4 - Day Habilitation with Transportation - Level 1-4 - Prevocational Services - Supported Employment - Individual Job Coach - Individual Job Developer - Occupational Therapy - Speech and Language Therapy - Physical Therapy - Behavior Therapy- Level 1-3 - In-Home Respite Care - Out-of-Home Respite Care - Institutional Respite Care - Personal Care - Personal Care on Worksite - Personal Care Transportation - Environmental Accessibility Adaptations - Specialized Medical Equipment - Medical Supplies - Skilled Nursing - Adult Companion Services - Crisis Intervention - Community Specialist	- Residential Habilitation in-Home - Day Habilitation-Level 1-4 - Day-Habilitation with Transportation - Level 1-4 - Prevocational Services - Supported Employment - Individual Job Coach - Individual Job Developer - Occupational Therapy Services - Speech and Language Therapy - Physical Therapy - Behavior Therapy- Level 1-3 - In-Home Respite - Out-of-Home Respite - Personal Care - Personal Care on Worksite - Personal Care Transportation - Environmental Accessibility Adaptations - Specialized Medical Equipment - Medical Supplies - Skilled Nursing - Community Specialist - Crisis Intervention	- Case Management ** - Personal Care - Personal Assistance Service - Environmental Accessibility Adaptations ** - Personal Emergency Response System (Initial Setup) - Personal Emergency Response System (Monthly Fee) - Medical Supplies - Minor Assistive Technology - Assistive Technology** - Evaluation for Assistive Technology - Assistive Technology Repairs **Includes Transitional Services	- Case Management - Homemaker Services - Personal Care - Respite Care - Skilled Nursing - Companion Services	- Private Duty Nursing - Personal Care/Attendant Services - Medical Supplies - Assistive Technology **Targeted Case Management (A covered service under Medicaid's State Plan)
Waiver criteria :	Nursing facility level of care	ICF/MR level of care	ICF/MR level of care	Nursing facility level of care	Nursing facility level of care	Nursing facility level of care
What groups can be eligible for this waiver?	- Individuals receiving SSI - Individuals receiving State Supplementation - SSI related protected groups deemed to be eligible for SSI / Medicaid - Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate - Federal or State Adoption Subsidy Individuals	- Individuals receiving SSI - SSI related protected groups deemed to be eligible for SSI / Medicaid - Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate - Low Income Families with Children - Federal or State Adoption Subsidy Individuals	- SSI recipients - Federal or State Adoption Subsidy Individuals - SSI related protected groups deemed to be eligible for SSI / Medicaid - Low Income Families with Children	- Individuals receiving SSI - Individuals receiving State Supplementation - SSI related protected groups deemed to be eligible for SSI / Medicaid - Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate	- Individuals receiving SSI - Disabled individuals with income up to 300% of the SSI income level	- Individuals receiving SSI - SSI related protected groups deemed to be eligible for SSI - Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate
Enrollment Limit:	9205	5,260	569	660	150	40
Is there an age requirement?	No age requirement	3 years and older	3 years and older	18 years and older	21 years and above	21 years and older
Who provides Case Management?	Dept of Senior Services Dept of Public Health	Dept of Mental Health	Dept of Mental Health	Dept of Rehabilitation Services	Dept of Public Health	Dept of Rehabilitation Services
Where to go to receive information on how to apply?	Dept of Senior Services www.adss.state.al.us Dept of Public Health www.adph.org	Dept of Mental Health www.mh.alabama.gov	Dept of Mental Health www.mh.alabama.gov	Dept of Rehabilitation Services www.rehab.state.al.us	Dept of Public Health www.adph.org	Alabama Medicaid Agency www.medicaid.alabama.gov
Who are the contact persons?	Jean Stone 1-800-243-5463 Glenda Harris 1-800-225-9770	Fordyce Mitchel 1-800-367-0955	Fordyce Mitchel 1-800-367-0955	Karen Coffey 1-800-441-7607	Glenda Harris 1-800-225-9770	Karen Coffey 1-800-441-7607
What are the reference sources?	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 36	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 35	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 52	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 57	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 58	Code of Federal Regulations: 42 CFR 440.160 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 54

**Specific medical diagnoses include, but are not limited to: Quadriplegia, Traumatic Brain Injury, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Spinal Muscular Atrophy, Muscular Dystrophy, Severe Cerebral Palsy, Stroke, and other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan disease)

Revised: 04-2010/lhc



medicaid and the uninsured

December 2008

Medicaid Home and Community-Based Service Programs: Data Update

By Terence Ng and Charlene Harrington, University of California San Francisco (UCSF)
and Molly O'Malley, Kaiser Family Foundation

EXECUTIVE SUMMARY

Developing home and community-based service (HCBS) alternatives to institutional care has been a priority for many state Medicaid programs over the last two decades. While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007. Recent fiscal problems at both the state and federal levels, however, will bring new uncertainties for the provision of Medicaid HCBS in the coming years. The deepening financial crisis is expected to impact the ability of many states to provide both acute and long-term care Medicaid services to the growing number of individuals eligible for Medicaid. This report presents a summary of the main trends to emerge from the latest (2005) expenditures and participant data for the three main Medicaid HCBS programs: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit. It also presents findings from the survey of policies used on the three main Medicaid HCBS programs and provider reimbursement rate data for the home health benefit and the personal care services benefit in 2007.

Key Findings:

- **In 2005, overall spending on Medicaid HCBS increased 10 percent.** The overall growth in spending (including 1915(c) waivers, home health, and personal care services) was slightly lower than the 13.3 percent growth rate in 2004. Spending growth on total HCBS programs in 2005 was led by the waiver program with 11 percent annual growth, followed by the home health benefit and the personal care program at 8 percent and 7 percent increases respectively.
- **Total enrollment in Medicaid HCBS programs increased 4 percent with almost 2.8 million individuals being served through these programs in 2005.** The percentage increase in enrollment was similar to the growth rate over the last year and down from an 8 percent increase in 2003. More than 1 million individuals were served through HCBS waivers, 924,259 individuals received care through the home health benefit and 794,642 individuals received the personal care services benefit. As the number of participants and expenditures continue to grow, variations continue to exist among the different types of programs and across states.

- **In 2007, all states reported using cost controls on HCBS waivers such as restrictive financial and function eligibility standards, enrollment limits, and waiting lists.** Almost a quarter (24%) of reporting waiver programs used more restrictive financial eligibility standards for HCBS waiver programs than for nursing facilities. However, only 7 waivers used more restrictive functional eligibility criteria for waivers than for institutional care. This year's survey also found an 18 percent increase in the number of persons on waiting lists for waiver services. In 2007, 331,689 individuals were on waiting lists, up from 280,176 in 2006. The average length of time an individual spent on a waiting list ranged from 9 months for aged waivers to 26 months for children's waivers.

INTRODUCTION

Developing home and community-based service (HCBS) alternatives to institutional care has been a priority for many state Medicaid programs over the last two decades. While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007.¹ States have responded to consumer preferences and the Supreme Court ruling in the *Olmstead* case, which confirms the discriminatory nature of policies that lead to the unnecessary institutionalization of participants on public programs such as Medicaid, in their efforts to direct state long-term care delivery systems toward more community-based care.² In 2008, Medicaid enrollment grew by 2.1 percent and expenditures grew by 5.3 percent, but the deepening financial crisis is expected to impact the ability of many states to provide Medicaid services to the growing number of individuals eligible for Medicaid. For fiscal year 2009, 30 states reported a budget deficit and this number is expected to expand as the country faces an economic downturn.³ These fiscal problems will bring new uncertainties for the provision of Medicaid HCBS in the coming years.

Over the last seven years, we have tracked the development of the three main Medicaid HCBS programs: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit. Beginning in 2002, we also surveyed the policies, such as eligibility criteria and waiting lists that states use to control spending growth in waiver programs. Starting from 2007, we expanded the policy survey to include the home health benefit and the state plan personal care services benefit and collected provider reimbursement rate data for both of these benefits. This report presents a summary of the main trends to emerge from the latest (2005) expenditures and participant data for the three Medicaid HCBS programs, and findings from the survey of policies used on 1915(c) waivers, the home health benefit and the optional state plan personal care services benefit in 2007.

MEDICAID HCBS PARTICIPANTS AND EXPENDITURES

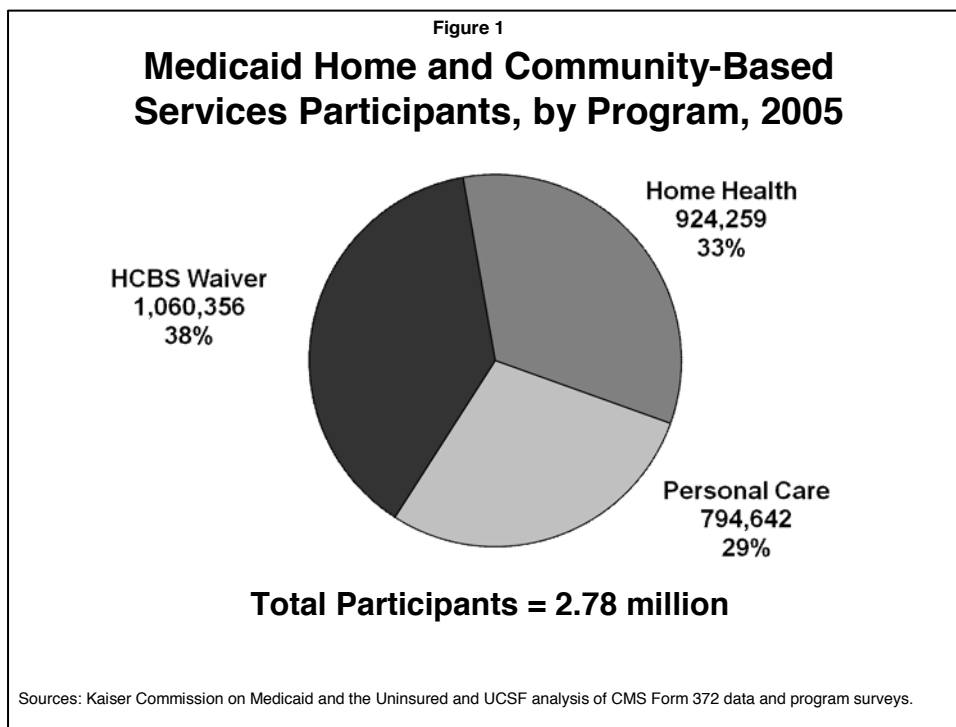
Medicaid Home Health, Personal Care Services, and 1915(c) Waiver Participants.

As noted above, there are three main ways a state can provide Medicaid HCBS: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit.

In 2005, all states operated the Medicaid home health benefit and multiple HCBS waivers (Arizona is a technical exception because it operates its Medicaid long-term care program under a Section 1115 demonstration waiver). The number of states actively offering the

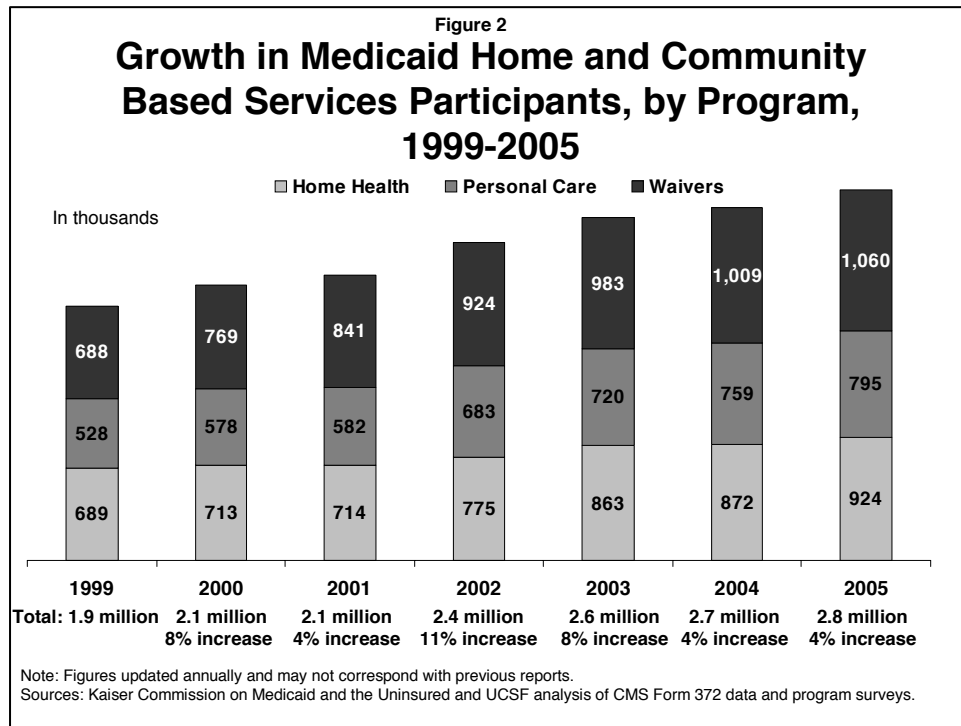
optional state plan personal care benefit remained constant at 30. (Two states had approval for personal care but did not have clients in their programs: Delaware and Rhode Island).

In 2005, almost 2.8 million individuals received Medicaid home and community-based services (Figure 1, Table 1A). Participation in HCBS programs increased 4 percent between 2004 and 2005, which was more than the 3.2 percent increase in total Medicaid enrollment in the same period.³ Of those enrollees, 1,060,356 individuals were served through HCBS 1915(c) waivers, 924,259 individuals received care through the home health benefit, and 794,642 individuals received personal care services through the optional state plan benefit (Table 1B, 1C, and 1D).



Between 1999 and 2005, the national number of individuals receiving Medicaid home and community-based services grew steadily each year by an average of 7 percent (Table 1A and Figure 2), which was more than the 5.6 percent average annual increase in total Medicaid enrollment in the same period.³ The higher growth in HCBS participants compared to total Medicaid participants indicate a growing demand for Medicaid HCBS services.

Over the 1999 to 2005 period there was, however, inter-state variation in average Medicaid HCBS participant annual growth rates ranged from large increases in North Carolina (23 percent), Hawaii and Mississippi (22 percent respectively), to reductions in New Hampshire (-6 percent) and Rhode Island (-4 percent). Declines in these states may be due to fiscal deficits or policy changes over the study period that curtailed Medicaid HCBS participation through discretionary cost control methods or legislative orders.

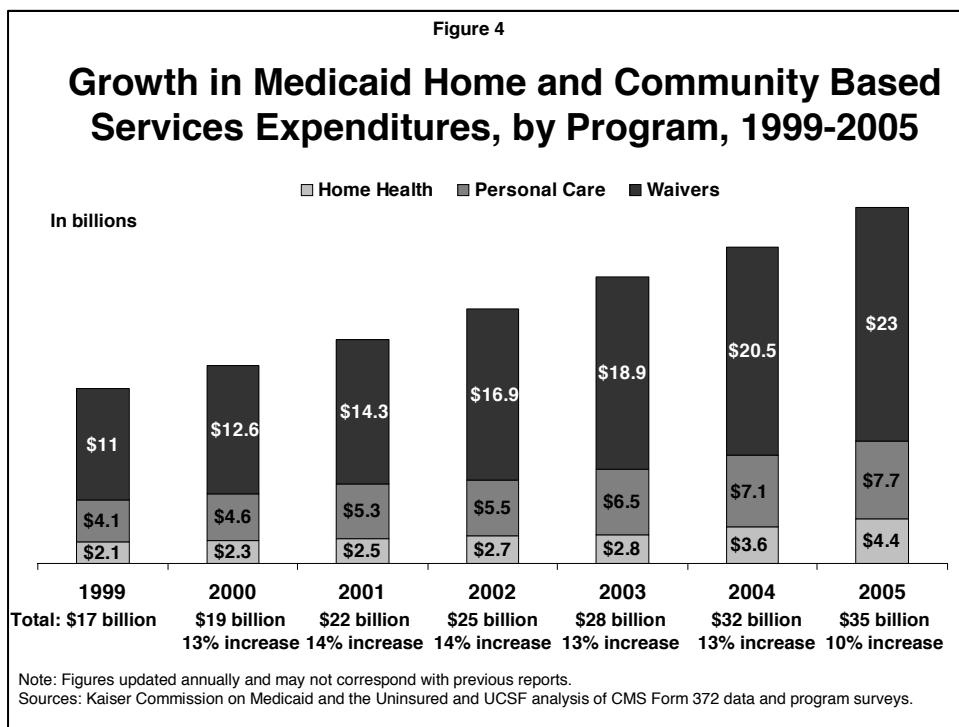
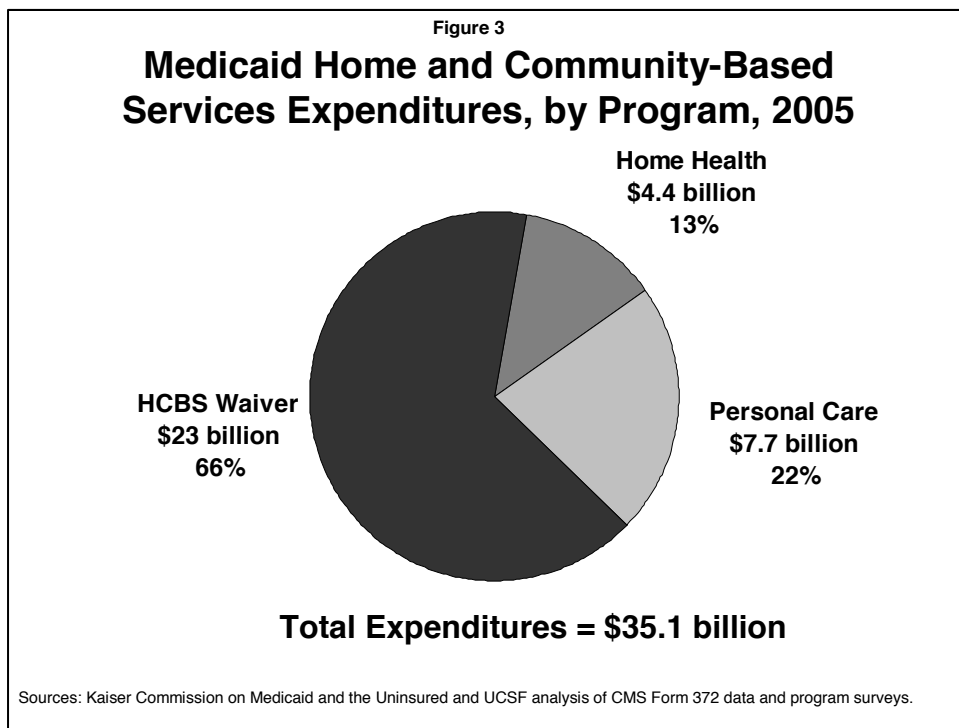


Between 2004 and 2005, there were also large inter-state variations in annual Medicaid HCBS participant growth rates ranging from highs of 21 percent in Maryland and 22 percent in Hawaii, to reductions of 19 percent in Mississippi and 5 percent in Ohio. In 2005, Maryland and Hawaii's home health program grew by 253 percent and 122 percent respectively. Of the states with the largest reported decline in Medicaid HCBS participants between 2004 and 2005, Mississippi home health participants declined by 39 percent and Ohio's home health participants declined by 12 percent.

Medicaid Home Health, Personal Care Services, and 1915(c) Waiver Expenditures.

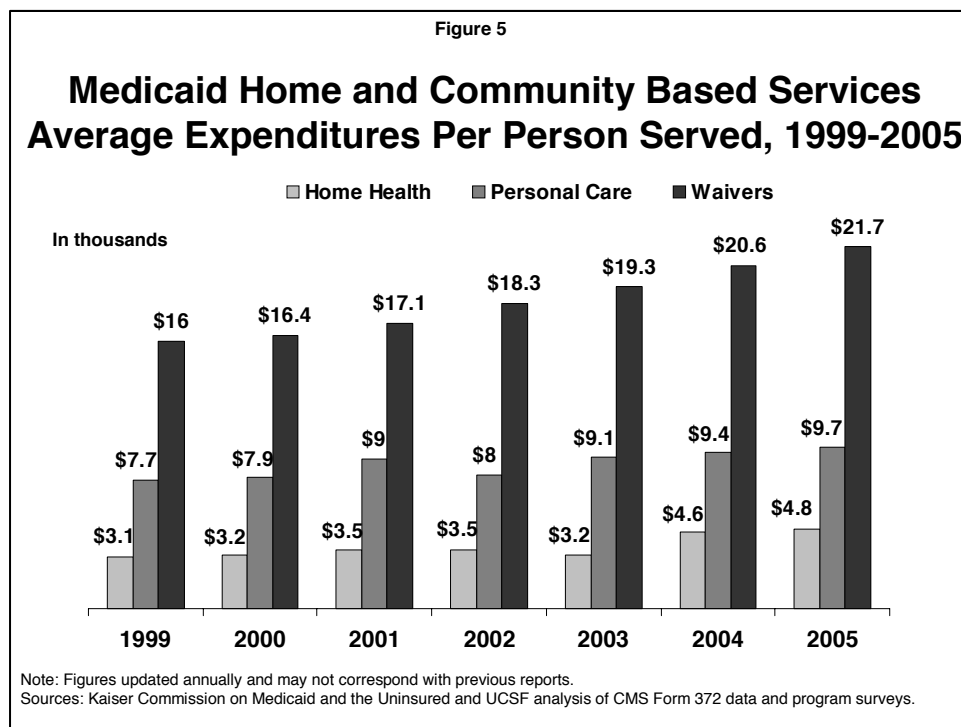
In 2005, total Medicaid spending on home and community-based services was \$35.1 billion (Table 2A). The large majority of Medicaid spending on non-institutional long-term care continued to occur through HCBS waivers. In 2005, Medicaid spending on HCBS waivers was \$23 billion, compared to \$7.7 billion on state plan personal care services, and \$4.4 billion on home health services (Tables 2B, 2C, 2D and Figure 3).

Between 1999 and 2005, total Medicaid spending on HCBS increased by almost \$18 billion (104 percent) or an average annual increase of 13 percent (Table 2A and Figure 4). This compares to an average annual increase of 10.5 percent for total Medicaid expenditures in the same period. Although there was a general trend of annual percentage increases in Medicaid HCBS expenditures and a 10 percent annual increase between 1999 and 2005, 4 states (Colorado, New Mexico, South Dakota and Vermont) recorded an annual decline in expenditures between 2004 and 2005 (Table 2A). The Medicaid HCBS annual growth rate between 2004 and 2005 was more than the 6.4 percent expenditure growth recorded for total Medicaid expenditures. This indicates that Medicaid HCBS expenditures as a proportion of Medicaid expenditures increased between 2004 and 2005 as it has done every year since 1999.



National total Medicaid home and community-based expenditure data masked three forms of variation. First, while national per person spending on Medicaid home and community-based services averaged \$12,627 in 2005, there was great variation among the states,

ranging from \$5,822 in Arkansas to \$37,052 in Rhode Island (Table 3A). Second, differences existed in spending across the programs. Per-person expenditures ranged from \$4,795 for home health participants to \$21,681 for waiver participants in 2005 (Table 3B, 3C, 3D and Figure 5). This difference was largely due to the types of services provided through the different home and community-based service options. Third, there was also significant per-person expenditure variation within the waiver programs among the different target groups.

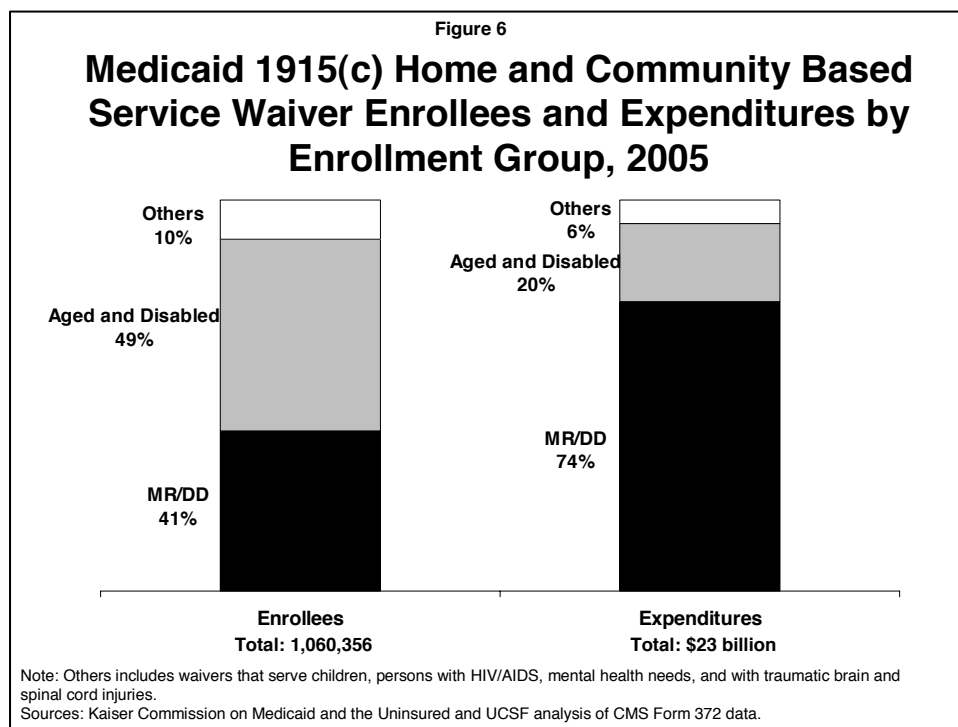


Medicaid 1915(c) Home and Community-Based Service Waivers. Between 2004 and 2005, the reported number of 1915(c) home and community-based service waivers rose to 272 from 262. Every state, except Arizona which operates its Medicaid long-term care program through a Section 1115 waiver, had multiple HCBS waivers targeted at a range of populations that are ‘at risk of institutional care.’ These groups included: the aged, aged or disabled, individuals with physical disabilities, individuals with mental retardation and developmental disabilities, medically fragile or technology dependent children, individuals with HIV/AIDS, and individuals with traumatic brain and spinal cord injury (TBI/SCI).

Table 4 details HCBS waivers by participants, expenditures and expenditures per person for the most recent years. In 2005, 1,060,356 participants were served through Medicaid HCBS waivers (Tables 4 and 5). This represented an increase of 51,250 individuals from 2004 (5 percent). As in previous years, the majority of participants (524,628) received services through waivers targeting the aged and aged or disabled, making up 49 percent of total waiver participants. The next largest group of participants (433,955) was enrolled in waivers for persons with mental retardation/ developmental disabilities (MR/DD) with 41 percent of waiver participants. Those with physical disabilities accounted for only 5 percent (57,714) of total waiver participants. The smallest waivers were for children with

special needs (17,354), individuals with HIV/AIDS (14,258), individuals with traumatic brain and spinal cord injuries (TBI/SCI) (10,580), and individuals with mental health needs (1,867). The HCBS waivers with the largest annual increase in participation were TBI/SCI (11%), followed by MR/DD (7%) and the aged (6%). A decline in participation was recorded in the mental health waivers (11%) (Table 4).

In 2005, overall expenditures for HCBS waivers increased 11 percent to \$23 billion. The vast majority of spending on HCBS waivers was on those targeting individuals with MR/DD. Although individuals in MR/DD waivers accounted for just 41 percent of total waiver participants, expenditures on these waivers accounted for 74 percent of all spending (Table 6 and Figure 6). Between 2004 and 2005, the annual rate of expenditure growth was highest for aged waivers (22%) and TBI/SCI waivers (17%), while expenditures on mental health waivers fell by 46 percent (Table 4). The large decline in expenditures on mental health waivers was due to a large drop in expenditures for both the Colorado and Vermont mental health waivers.



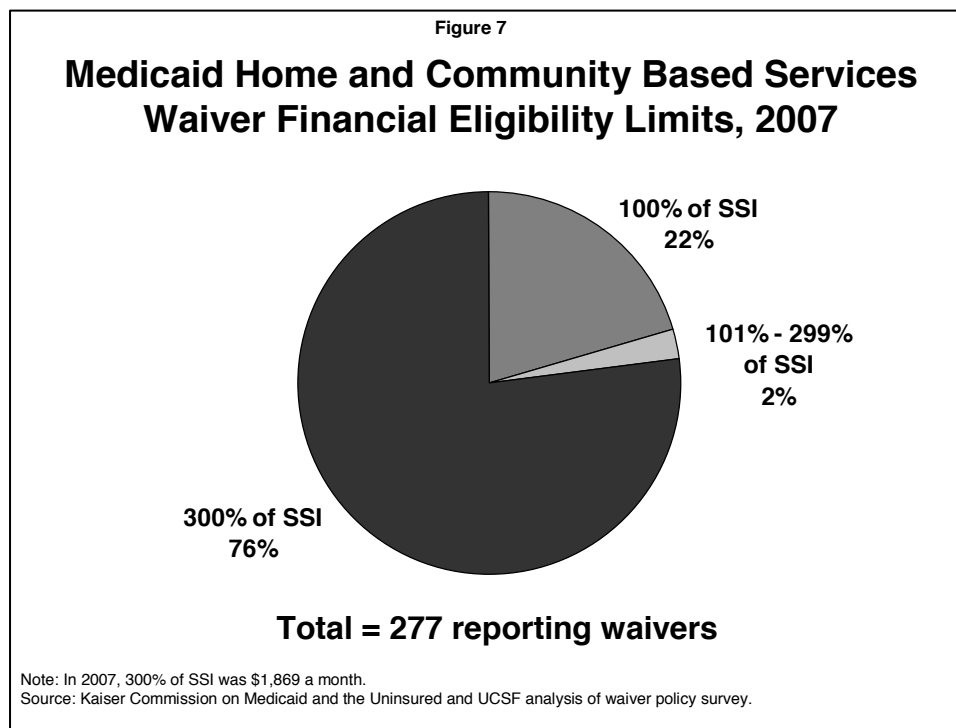
Average waiver expenditures per participant increased by 5 percent from 2004-2005 (Table 4). As a result of individuals with MR/DD having extensive health care needs, the average spending per person was highest for this group (\$39,314) (Table 7). This amount was nearly 5 times higher than average waiver spending on the aged and the aged/disabled. Expenditures per participant grew by 15 percent for those in aged waivers, while declining by 40 percent for mental health waivers and by 4 percent for children's waivers (Table 4).

ELIGIBILITY AND COST CONTAINMENT POLICIES USED ON HOME AND COMMUNITY-BASED SERVICES

Medicaid 1915(c) Home and Community-Based Service Waivers

The Medicaid 1915(c) waiver program allows states to use a broad range of cost-containment strategies to meet federal waiver cost neutrality requirements and to limit waiver spending so that costs do not exceed state budgetary restrictions. To understand how states controlled spending on home and community-based service waivers in 2007, we surveyed all HCBS waiver program administrators asking about their financial and functional eligibility standards, whether they used enrollment and/or expenditure caps, if they used waiting lists, and if so, how many individuals were on the lists and the average length of time an individual spent on the list.⁴ The survey findings showed that every state used some type of cost-containment tool in their waivers (over and above the requirement that all per-person waiver spending is kept lower than equivalent institutional care). Cost controls included restrictive financial and functional eligibility standards, enrollment limits, and waiting lists. The following summarizes the survey findings to illustrate how states use cost control policies to control access to home and community-based waiver services.

Financial Eligibility. Most states set nursing facility financial eligibility at 300 percent of SSI (\$1,869/month in 2007). States may set financial eligibility standards for Medicaid 1915(c) HCBS waivers at the same level as that for nursing facilities. There is, however, wide variation across states and HCBS waiver programs as shown in Table 8. The survey found that 24 percent of reporting waiver programs used more restrictive financial eligibility standards than for nursing facilities (Table 8 and Figure 7).



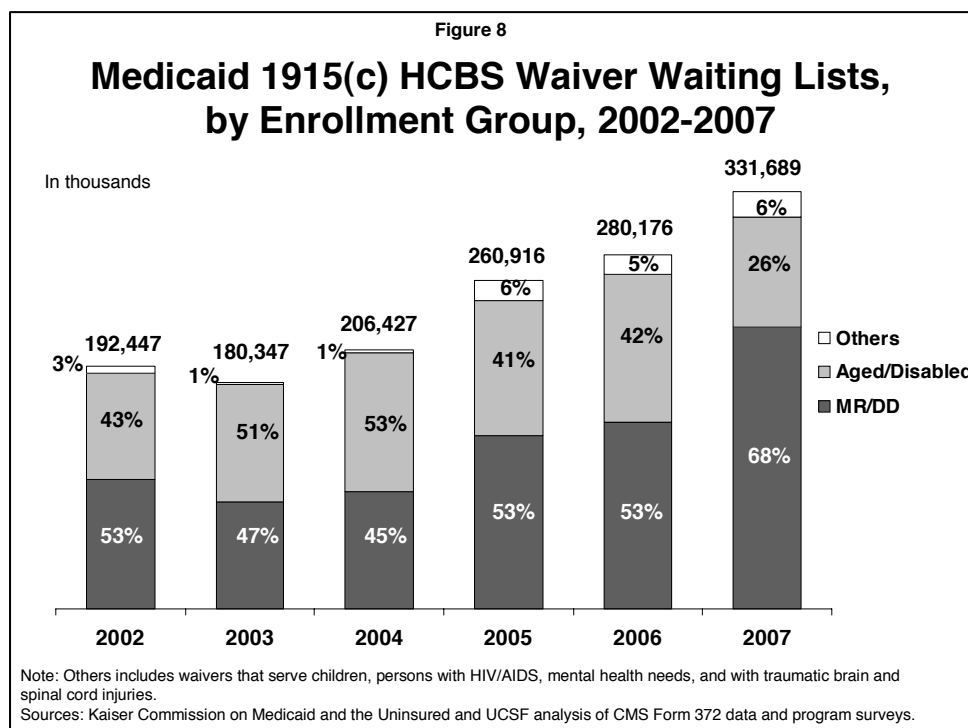
Functional Eligibility. Another way states can limit eligibility for home and community-based service waivers is by setting functional eligibility criteria that are stricter than those used for care in a nursing facility. For example, a state could require an individual to exhibit difficulty in performing 4 Activities of Daily Living (ADLs), such as bathing, dressing, transferring, eating, toileting, instead of only 3 ADLs required for nursing facility admission. The survey found that only 7 waivers used more restrictive functional eligibility criteria for waivers than for institutional care (no Table shown). These waivers were reported in Alabama, California, Washington DC, Florida, New York, Texas and Utah.

Cost Controls. More than two-thirds of all waiver states (69%) utilized some form of cost controls above and beyond the federally mandated cost neutrality formula in 2007. Many states used a mixture of fixed expenditure cap, service provision and hourly cap, and geographic limits within the states (Table 9). Almost half of the states with waiver cost controls (15 of 34 states) utilized more than one form of cost controls such as a combination of expenditure caps and service limitations.

Consumer Direction. In response to the President's New Freedom Initiative and the impending Deficit Reduction Act, many states also incorporated some form of mandatory or optional consumer direction within their waivers. Consumer direction can include initiatives such as consumer choice in the allocation of their service budgets or the hiring and firing of service providers. In 2007, 96 waivers in 33 states (37 percent of waiver states) allowed or required some consumer direction (Table 9). This marks an increase of 9 waivers and 3 states that allowed consumer direction in their waivers between 2006 and 2007.

Waiting Lists. States often have more individuals in need of waiver services than the number of available spaces, called 'slots', in a program (Table 10). Many states used waiting lists when their program slots are filled. In 2007, 37 states reported waiting lists and 10 states said they did not have waiting lists (Table 11). In 2007, there were 106 waivers with waiting lists with 331,689 individuals on waiver waiting lists. Waivers for the MR/DD population had the greatest number of individuals on waiting lists (224,147) followed by waivers serving the aged and aged/disabled (87,338) (Table 11, Figure 8). Most states estimate that a large percentage of the persons on a waiver waiting list reside in the community, rather than in an institution.

Compared to the previous year, the number of individuals on waiver waiting lists increased by more than 18 percent, with growth concentrated on the MR/DD, aged/disabled and children's waivers. This increase in waiting lists illustrates the growing demand for waiver services, especially among the MR/DD community, even as the number of waivers and waiver participants and expenditures increased. Due to the varying number of waiver slots available for each enrollment group, the average length of time an individual spends on a waiting list also varied by type of population, from 9 months for aged waivers to 26 months for children's waivers and 25 months for MR/DD waivers. The long average wait times for the MR/DD and children's waivers were the result of large and long waiting lists in 2 Louisiana waivers.



In 2007, 72 percent of all waivers with waiting lists had a policy of screening individuals for Medicaid waiver eligibility before being placed or while on a waiting list (Table 10). In addition, almost two-thirds of all waivers with waiting lists (63%) had a policy of prioritizing individuals for waiver services (e.g. persons transitioning from an institution get priority for waiver services when slots become available). More than 80 percent of all states with waiver waiting lists provided non-waiver services such as state plan services to Medicaid eligible individuals while they waited for waiver services.

Medicaid Home Health and State Plan Personal Care Programs

Unlike the waiver program, the Medicaid home health and the optional state plan personal care programs do not allow states the ability to maintain waiting lists or geographically limit the provision of service.⁵ However, federal Medicaid rules allow states to use certain cost-containment strategies. To understand how states control spending in home health and the optional state plan personal care programs in 2007, we surveyed all Medicaid home health and state plan personal care programs asking about financial eligibility standards, whether they used any form of expenditure or service caps, and whether or not they allowed consumers to hire and fire their service providers (which we used as a proxy for consumer direction). The following summarizes the survey findings to show how states use cost control policies to control access to home health and optional state plan personal care services.⁶

Financial Eligibility. Most states utilized the minimum Medicaid standard of categorically needy to admit participants into the programs. However, states may elect to expand the financial eligibility criteria by allowing the medically needy (those who spend down) and those on the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program to receive services under these programs. In 2007, in addition to the categorically needy, 82 percent of state home health program and 56 percent of states with optional state plan

personal care programs allowed either the medically needy or those on the EPSDT program or both to participate in the programs (Table 9).

Cost Controls. More than one-third of all states (35%) utilized either expenditure or service limits or both in their home health programs in 2007 while 47 percent of all states with optional state plan personal care programs used cost control limits. However, only 1 state (Connecticut) used a combination of expenditure and service limits on its home health program while Maryland was the only state to impose such a combination of limits on its optional state plan personal care program. Service limitations were the most popular form of cost control among states with optional state plan personal care service programs with 44 percent of all states using such limits as their sole form of cost controls.

Consumer Direction. Between 2006 and 2007, there was no change in the percentage of home health programs allowing consumer direction within their program with less than a quarter (24%) of programs allowing consumer direction. In contrast, there was an increase in the number of optional state plan personal care programs that allowed consumer direction (from 31 percent of states in 2006 to 47 percent of states in 2007). For the HCBS waiver programs, 80 percent of programs allowed consumer direction in at least some of their waivers in 2007.

Provider Reimbursement. The average reimbursement that states provided to home health agencies was \$71.98 per home health visit in 2007. In states that paid registered nurses (RNs) or home health aides (HHA) directly or mandated their reimbursement rates, the average rate for RNs was \$79.95 per visit and \$38.95 per visit for HHAs. In the optional state plan personal care program, the average rate paid to agencies providing personal care was \$15.89 per hour in 2007. In states where personal care providers were paid directly by the state or where reimbursement rates were determined by the state, the average reimbursement rate was \$12.09 per hour in 2007 (Table 12).⁷ Reimbursement rates for services provided under 1915(c) HCBS waivers were not part of the policy survey and are not reported here. Medicaid services reimbursement rates are set by individual state legislatures as part of the state's budgetary process.

CONCLUSION

Over the past two decades, policy makers have responded to consumer preferences for alternatives to institutional care, by expanding Medicaid home and community-based programs. In 2005, the number of Medicaid enrollees receiving HCBS services grew to 2.8 million, a 4 percent increase over the previous year. Although the number of Medicaid enrollees in HCBS waivers also increased in 2005, the rapid increase in the number of individuals on waiting lists highlights the demand for services, especially those serving the MR/DD and aged/disabled population. In addition, inter-state variations in Medicaid HCBS programs and spending are still a concern. States that are using more restrictive financial or functional eligibility standards in their HCBS programs are at odds with the desire to serve more Medicaid beneficiaries in community-based setting. As the deepening fiscal crisis continues, states will be faced with new uncertainties for the provision of Medicaid HCBS services in the coming years. Therefore, targeted research is needed to investigate the impact of cost controls on access, quality and overall Medicaid costs as well as the differences in services and spending across states.

The use of some form of consumer direction in two-thirds of waiver states highlights the need to better understand the impact of the increasing number of Medicaid HCBS

enrollees who are able to self direct their care and employ their preferred caretakers. The emergence and adoption of Independence Plus waivers and other demonstrations such as Money Follows the Persons grants within the framework of existing waivers highlights a trend towards the use of consumer directed home care and more research is required to understand the impact such waivers are having on access, quality, and costs.

Endnotes

¹ Burwell, B., Sredl, K., and Eiken, S., 2007. *Medicaid Long Term Care Expenditures in FY 2007*. Thomson Reuters, September 2008.

<http://www.hcbs.org/files/145/7239/2007LTCExpenditures.pdf>

² Kitchener M., and C. Harrington. 2005. "U.S. Long-term Care: A Dialectic Analysis of Institutional Dynamics." *Journal of Health and Social Behavior* 45: 87-101.

³ Smith, V. et. al. *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn*. Kaiser Commission on Medicaid and the Uninsured. Issue Paper, September 2008. <http://kff.org/medicaid/7815.cfm>

⁴ Out of 277 active waivers in 2007, 262 HCBS waiver surveys were completed. The response rate was 94 percent.

⁵ Kitchener M., T. Ng. and C. Harrington. 2007. "State Medicaid Home Care Policies: Inside the Black Box." *Home Health Care Services Quarterly*. Volume 26, No. 3; 23-38

⁶ Completed policy surveys were collected for all 51 Medicaid Home Health programs and all 32 Medicaid State Plan Personal Care programs.

⁷ Average reimbursement rates for home health and personal care services programs were calculated by standardizing the payment period (per visit for the home health program and per hour for the personal care services program).

Table 1A: Total Medicaid HCBS Participants, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change	99-05 ave. % change
Total	1,905,175	2,061,116	2,137,012	2,382,049	2,565,186	2,660,001	2,779,257	4%	7%
AK	3,407	3,973	4,583	5,328	6,365	6,306	6,611	5%	12%
AL	17,719	18,042	19,455	19,235	19,766	19,723	20,329	3%	2%
AR	38,418	37,073	36,498	34,414	33,506	33,970	34,371	1%	-2%
AZ	26,351	28,463	31,170	33,897	36,338	38,077	39,717	4%	7%
CA	318,608	346,640	335,250	421,556	446,510	454,476	481,400	6%	7%
CO	27,047	28,931	32,476	34,293	33,615	34,270	34,262	0%	4%
CT	39,568	41,191	42,398	38,782	38,053	39,467	40,025	1%	0%
DC	4,452	4,571	4,299	4,238	5,081	5,258	5,430	3%	4%
DE	2,709	2,755	3,128	3,258	3,459	3,550	3,631	2%	5%
FL	59,768	68,611	75,528	84,974	85,604	87,836	94,323	7%	8%
GA	25,956	24,420	28,111	33,513	35,599	37,788	38,700	2%	7%
HI	2,546	2,816	6,391	6,547	6,277	4,643	5,663	22%	22%
IA	26,771	27,790	30,267	32,968	37,089	42,110	42,618	1%	8%
ID	6,265	8,765	10,579	10,754	13,021	15,827	16,541	5%	18%
IL	69,194	72,874	83,905	94,244	111,227	118,960	143,189	20%	13%
IN	14,030	13,728	13,360	16,221	19,601	22,413	22,363	0%	9%
KS	18,185	21,296	22,356	24,343	25,338	27,767	29,213	5%	8%
KY	34,783	36,025	40,322	41,654	42,514	39,063	37,337	-4%	1%
LA	14,508	18,928	15,662	16,271	18,258	19,889	21,601	9%	8%
MA	45,926	48,244	47,772	47,002	48,196	46,212	50,668	10%	2%
MD	15,717	17,283	18,772	17,170	20,215	19,478	23,502	21%	7%
ME	11,755	10,624	8,462	8,890	13,963	14,920	14,797	-1%	6%
MI	65,841	69,987	74,466	74,784	78,988	79,841	79,180	-1%	3%
MN	34,603	39,726	47,434	50,609	51,577	56,005	59,325	6%	10%
MO	71,263	77,133	80,314	83,734	83,771	88,565	89,244	1%	4%
MS	8,243	10,279	18,662	21,844	23,613	28,956	23,374	-19%	22%
MT	6,241	6,504	6,532	6,705	6,525	7,303	7,558	3%	3%
NC	36,189	40,211	42,680	76,100	84,254	95,880	110,889	16%	23%
ND	3,169	3,412	2,713	3,171	4,126	5,159	5,511	7%	11%
NE	8,374	11,247	12,372	12,255	14,547	15,065	16,024	6%	12%
NH	13,779	13,875	6,829	7,586	8,023	8,117	7,765	-4%	-6%
NJ	47,616	47,827	36,109	43,290	47,443	46,089	48,462	5%	1%
NM	7,574	9,120	7,784	11,503	15,121	15,932	16,061	1%	15%
NV	2,894	3,297	4,992	6,039	6,914	7,194	7,429	3%	18%
NY	257,850	254,556	248,277	249,680	250,697	271,675	271,631	0%	1%
OH	60,386	80,754	63,377	74,481	133,828	143,989	136,484	-5%	19%
OK	21,041	29,697	30,072	31,906	28,685	30,214	32,750	8%	9%
OR	33,644	37,852	41,879	45,557	44,441	43,722	44,622	2%	5%
PA	28,525	31,615	55,193	72,088	48,152	53,842	55,606	3%	16%
RI	8,422	7,404	8,864	6,039	6,105	6,331	6,568	4%	-3%
SC	30,280	29,825	29,488	31,595	31,017	31,213	31,441	1%	1%
SD	8,973	8,733	8,775	8,963	8,971	9,230	9,155	-1%	0%
TN	10,416	10,643	10,606	11,198	12,573	17,735	19,024	7%	11%
TX	181,003	215,279	248,318	269,324	309,152	291,625	317,970	9%	10%
UT	4,856	5,822	6,260	6,029	6,896	8,942	8,903	0%	11%
VA	22,617	21,708	20,495	20,610	20,428	20,536	22,735	11%	0%
VT	5,912	6,338	6,801	8,718	8,510	9,061	8,954	-1%	8%
WA	45,087	48,247	50,757	53,601	63,689	64,336	63,359	-2%	6%
WI	41,582	41,688	39,443	47,268	49,148	52,837	54,111	2%	5%
WV	12,596	12,687	13,837	14,531	14,878	14,973	14,875	-1%	3%
WY	2,516	2,607	2,939	3,289	3,519	3,631	3,956	9%	8%

Notes:

Total Medicaid HCBS comprises Medicaid Home Health, Medicaid Personal Care Services, and Medicaid 1915(c) HCBS waivers.

Table 1B: Medicaid Home Health Participants, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	688,781	713,186	713,505	775,299	862,607	891,737	924,259	4%
AK	519	288	261	232	286	273	304	11%
AL	7,564	7,801	7,924	7,008	6,576	6,345	6,757	6%
AR	10,039	8,950	8,228	7,189	6,772	6,642	6,788	2%
AZ	26,351	28,463	31,170	33,897	36,338	38,077	39,717	4%
CA	99,938	90,478	81,250	77,834	89,436	87,027	87,027	0%
CO	7,120	6,741	8,551	8,789	7,326	8,275	8,687	5%
CT	25,753	26,372	26,619	22,143	20,933	21,446	21,753	1%
DC	2,799	2,802	2,349	2,030	2,124	2,124	2,124	0%
DE	1,120	985	1,072	989	989	989	989	0%
FL	14,793	14,192	14,324	15,305	17,476	19,962	21,192	6%
GA	9,330	7,705	7,309	8,827	10,913	13,102	14,014	7%
HI	609	555	3,478	3,239	2,726	585	1,300	122%
IA	17,616	17,132	17,939	18,670	20,548	23,346	24,558	5%
ID	2,518	2,992	3,164	1,999	1,794	3,295	3,326	1%
IL	30,092	30,373	37,718	41,546	51,060	53,932	74,236	38%
IN	9,694	8,790	8,154	9,232	8,235	8,939	8,879	-1%
KS	1,443	2,830	2,597	2,716	6,688	7,152	5,865	-18%
KY	20,326	20,280	22,916	23,168	24,636	23,702	22,415	-5%
LA	10,751	14,371	10,560	10,836	11,051	11,662	12,187	5%
MA	26,000	25,000	22,865	20,177	19,521	16,498	17,875	8%
MD	6,696	7,469	7,639	3,291	3,598	1,245	4,393	253%
ME	6,947	5,515	3,234	3,050	3,140	2,875	2,875	0%
MI	7,286	4,145	4,772	5,720	8,301	7,080	6,573	-7%
MN	8,433	9,488	8,894	7,878	5,174	5,349	5,229	-2%
MO	5,997	6,242	6,043	6,806	7,237	7,246	7,739	7%
MS	5,228	5,639	7,812	9,283	10,351	14,543	8,834	-39%
MT	982	820	571	540	456	473	437	-8%
NC	10,665	11,590	12,468	32,487	33,206	35,871	38,668	8%
ND	963	1,092	257	205	803	899	521	-42%
NE	2,738	4,350	4,812	5,193	5,602	5,532	6,292	14%
NH	9,684	9,408	1,953	2,177	2,300	2,389	2,841	19%
NJ	14,433	12,910	4,541	10,219	10,219	10,219	10,219	0%
NM	4,206	4,518	530	487	609	391	431	10%
NV	350	400	1,453	1,455	1,551	1,551	1,551	0%
NY	111,014	103,402	93,517	92,715	89,844	110,910	109,244	-2%
OH	26,523	45,953	32,810	34,868	89,857	96,408	84,374	-12%
OK	3,187	3,423	3,630	3,735	3,006	3,841	5,129	34%
OR	756	889	1,719	2,245	2,245	2,245	2,245	0%
PA	11,579	8,601	24,160	36,381	8,071	9,171	9,359	2%
RI	3,227	1,805	2,847	1,000	1,000	1,000	1,000	0%
SC	10,256	9,267	8,825	11,100	11,100	11,100	11,100	0%
SD	5,480	5,212	4,729	4,729	4,729	4,729	4,729	0%
TN	5,560	5,733	5,616	6,300	7,648	12,655	12,539	-1%
TX	78,061	104,292	129,559	157,095	186,870	170,881	187,099	9%
UT	1,135	1,370	1,476	759	1,488	2,214	2,121	-4%
VA	6,374	6,031	4,970	4,468	3,831	2,890	3,299	14%
VT	3,120	3,271	3,376	3,434	3,501	3,611	3,611	0%
WA	3,950	3,501	3,818	3,410	3,231	2,858	3,597	26%
WI	7,526	7,664	6,765	6,180	5,903	5,903	5,903	0%
WV	1,626	1,656	1,785	1,749	1,749	1,749	1,749	0%
WY	424	430	476	514	559	536	565	5%

Source: Kaiser Commission and UCSF analysis of Medicaid Home Health Policy Survey.

Table 1C: Medicaid Personal Care Services Participants, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	528,412	578,207	582,298	683,067	719,852	759,158	794,642	5%
AK	1,242	1,456	1,584	1,955	2,742	2,742	2,742	0%
AL								
AR	18,358	17,716	16,823	15,870	15,499	15,503	15,452	0%
AZ								
CA	176,822	211,619	203,345	283,750	288,000	295,049	313,893	6%
CO								
CT								
DC	1,624	1,625	1,649	1,710	2,352	2,352	2,352	0%
DE	0	0	0	0	0	0	0	0%
FL	8,517	9,463	10,515	14,791	14,659	14,718	13,980	-5%
GA								
HI								
IA								
ID	2,196	1,921	1,823	2,253	3,377	3,614	3,601	0%
IL								
IN								
KS								
KY								
LA								
MA	3,718	5,666	6,938	9,000	10,570	11,716	13,767	18%
MD	4,627	4,677	4,704	4,832	4,743	4,603	4,643	1%
ME	1,092	1,289	1,388	1,894	6,627	7,861	7,861	0%
MI	43,394	46,309	47,920	51,425	53,351	54,986	55,158	0%
MN	7,111	7,317	7,773	7,506	6,302	8,329	9,940	19%
MO	36,575	39,203	41,111	43,964	44,835	49,295	49,481	0%
MS								
MT	2,765	2,794	2,925	2,996	2,864	2,990	3,124	4%
NC	9,085	11,236	12,667	27,064	34,058	41,911	50,818	21%
ND				450	450	777	1,362	75%
NE	862	1,109	1,168	1,208	1,301	1,356	1,549	14%
NH	122	124	38	35	26	25	25	0%
NJ	19,704	20,592	15,639	16,430	17,707	18,987	20,884	10%
NM		883	3,170	6,357	8,960	9,525	9,614	1%
NV	491	449	795	1,501	2,038	2,038	2,038	0%
NY	89,577	88,788	88,370	84,879	83,846	85,613	84,270	-2%
OH								
OK	6,159	7,473	7,011	10,000	7,000	7,000	7,000	0%
OR	1,265	2,070	2,678	1,920	2,376	4,495	5,086	13%
PA								
RI	0	0	0	0	0	0	0	0%
SC								
SD	886	994	1,015	1,057	948	923	901	-2%
TN								
TX	67,661	70,284	77,824	62,366	66,967	71,381	77,725	9%
UT	181	279	318	348	450	1,787	1,755	-2%
VA								
VT				1,563	1,359	1,534	1,534	0%
WA	7,625	6,514	7,208	11,000	21,436	22,390	18,429	-18%
WI	11,067	10,508	10,587	10,408	10,474	11,123	11,123	0%
WV	5,686	5,849	5,312	4,535	4,535	4,535	4,535	0%
WY								

Notes:

Personal care services are an optional benefit. In 2005, 30 states reported personal care services participants. Blank cells mean no program offered. Two states (DE and RI) were approved by CMS to offer personal care services but did not report participants during the period.

Source: Kaiser Commission and UCSF analysis of Medicaid Personal Care Services Policy Survey

Table 1D: Medicaid 1915(c) HCBS Waivers Participants, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	687,982	769,723	841,209	923,683	982,727	1,009,106	1,060,356	5%
AK	1,646	2,229	2,738	3,141	3,337	3,291	3,565	8%
AL	10,155	10,241	11,531	12,227	13,190	13,378	13,572	1%
AR	10,021	10,407	11,447	11,355	11,235	11,825	12,131	3%
AZ								
CA	41,848	44,543	50,655	59,972	69,074	72,400	80,480	11%
CO	19,927	22,190	23,925	25,504	26,289	25,995	25,575	-2%
CT	13,815	14,819	15,779	16,639	17,120	18,021	18,272	1%
DC	29	144	301	498	605	782	954	22%
DE	1,589	1,770	2,056	2,269	2,470	2,561	2,642	3%
FL	36,458	44,956	50,689	54,878	53,469	53,156	59,151	11%
GA	16,626	16,715	20,802	24,686	24,686	24,686	24,686	0%
HI	1,937	2,261	2,913	3,308	3,551	4,058	4,363	8%
IA	9,155	10,658	12,328	14,298	16,541	18,764	18,060	-4%
ID	1,551	3,852	5,592	6,502	7,850	8,918	9,614	8%
IL	39,102	42,501	46,187	52,698	60,167	65,028	68,953	6%
IN	4,336	4,938	5,206	6,989	11,366	13,474	13,484	0%
KS	16,742	18,466	19,759	21,627	18,650	20,615	23,348	13%
KY	14,457	15,745	17,406	18,486	17,878	15,361	14,922	-3%
LA	3,757	4,557	5,102	5,435	7,207	8,227	9,414	14%
MA	16,208	17,578	17,969	17,825	18,105	17,998	19,026	6%
MD	4,394	5,137	6,429	9,047	11,874	13,630	14,466	6%
ME	3,716	3,820	3,840	3,946	4,196	4,184	4,061	-3%
MI	15,161	19,533	21,774	17,639	17,336	17,775	17,449	-2%
MN	19,059	22,921	30,767	35,225	40,101	42,327	44,156	4%
MO	28,691	31,688	33,160	32,964	31,699	32,024	32,024	0%
MS	3,015	4,640	10,850	12,561	13,262	14,413	14,540	1%
MT	2,494	2,890	3,036	3,169	3,205	3,840	3,997	4%
NC	16,439	17,385	17,545	16,549	16,990	18,098	21,403	18%
ND	2,206	2,320	2,456	2,516	2,873	3,483	3,628	4%
NE	4,774	5,788	6,392	5,854	7,644	8,177	8,183	0%
NH	3,973	4,343	4,838	5,374	5,697	5,703	4,899	-14%
NJ	13,479	14,325	15,929	16,641	19,517	16,883	17,359	3%
NM	3,368	3,719	4,084	4,659	5,552	6,016	6,016	0%
NV	2,053	2,448	2,744	3,083	3,325	3,605	3,840	7%
NY	57,259	62,366	66,390	72,086	77,007	75,152	78,117	4%
OH	33,863	34,801	30,567	39,613	43,971	47,581	52,110	10%
OK	11,695	18,801	19,431	18,171	18,679	19,373	20,621	6%
OR	31,623	34,893	37,482	41,392	39,820	36,982	37,291	1%
PA	16,946	23,014	31,033	35,707	40,081	44,671	46,247	4%
RI	5,195	5,599	6,017	5,039	5,105	5,331	5,568	4%
SC	20,024	20,558	20,663	20,495	19,917	20,113	20,341	1%
SD	2,607	2,527	3,031	3,177	3,294	3,578	3,525	-1%
TN	4,856	4,910	4,990	4,898	4,925	5,080	6,485	28%
TX	35,281	40,703	40,935	49,863	55,315	49,363	53,146	8%
UT	3,540	4,173	4,466	4,922	4,958	4,941	5,027	2%
VA	16,243	15,677	15,525	16,142	16,597	17,646	19,436	10%
VT	2,792	3,067	3,425	3,721	3,650	3,916	3,809	-3%
WA	33,512	38,232	39,731	39,191	39,022	39,088	41,333	6%
WI	22,989	23,516	22,091	30,680	32,771	35,811	37,085	4%
WV	5,284	5,182	6,740	8,247	8,594	8,689	8,591	-1%
WY	2,092	2,177	2,463	2,775	2,960	3,095	3,391	10%

Notes: AZ did not operate an 1915(c) waiver over the study period because all HCBS were provided through a 1115 demonstration waiver.

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 2A: Total Medicaid HCBS Expenditures, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change	99-05 ave. % change
Total	\$17,209,159,864	\$19,441,712,416	\$22,080,281,206	\$25,093,663,716	\$28,238,928,934	\$31,996,470,808	\$35,093,334,480	10%	13%
AK	45,354,603	60,668,035	82,342,961	108,675,096	145,679,182	154,531,603	156,193,181	1%	24%
AL	151,379,502	157,186,412	167,443,330	208,950,350	212,282,000	237,214,211	273,376,248	15%	11%
AR	131,108,700	134,880,377	156,687,033	161,753,874	163,560,431	177,833,534	200,102,642	13%	7%
AZ	297,373,001	291,851,598	337,986,311	429,912,053	502,729,562	571,602,786	642,134,311	12%	14%
CA	1,872,821,444	2,200,718,334	2,717,657,118	2,923,983,809	3,598,497,867	4,024,635,957	4,387,670,377	9%	15%
CO	269,941,242	344,787,435	386,343,329	422,691,842	459,336,759	464,007,995	461,164,769	-1%	10%
CT	489,485,893	521,869,339	574,720,005	619,224,038	669,221,314	677,714,199	701,998,029	4%	6%
DC	13,583,477	14,352,419	15,456,361	20,131,053	26,774,769	31,255,169	33,165,381	6%	17%
DE	41,452,591	45,623,139	52,706,270	56,240,464	72,062,289	67,340,868	74,056,017	10%	11%
FL	317,211,333	417,181,845	600,582,595	725,879,503	813,748,583	919,013,161	1,001,616,503	9%	22%
GA	179,626,943	201,434,029	220,292,847	314,867,191	320,869,839	323,004,902	332,942,801	3%	12%
HI	35,781,922	43,466,894	58,298,561	72,492,240	78,699,481	108,280,113	120,841,624	12%	23%
IA	131,940,852	152,718,538	182,056,614	214,269,060	251,652,690	285,540,027	352,321,149	23%	18%
ID	41,236,756	57,217,545	76,002,328	90,381,223	112,676,988	134,245,371	146,702,041	9%	24%
IL	346,485,656	389,705,482	486,669,111	574,527,277	680,919,272	763,480,105	861,360,464	13%	16%
IN	132,015,293	152,777,006	107,738,424	245,868,088	372,148,363	471,503,989	486,249,836	3%	33%
KS	241,349,904	278,416,722	302,162,352	321,911,865	346,806,799	364,019,070	368,930,830	1%	7%
KY	159,830,708	197,041,417	232,773,860	252,313,712	249,305,892	245,137,580	277,331,722	13%	10%
LA	96,557,594	104,425,978	151,158,394	169,477,083	201,611,716	434,731,870	571,720,660	32%	39%
MA	583,137,929	653,597,435	714,635,538	772,989,266	816,117,057	884,524,974	942,338,162	7%	8%
MD	227,115,049	251,869,746	282,708,591	286,278,982	375,900,068	460,525,684	516,094,476	12%	15%
ME	139,401,524	150,670,026	163,050,532	192,328,168	234,802,021	274,236,809	278,492,687	2%	12%
MI	499,086,768	685,508,213	650,573,808	667,412,435	583,723,255	627,636,623	631,301,204	1%	5%
MN	598,479,361	741,371,315	869,179,708	1,112,926,385	1,145,026,341	1,222,684,033	1,374,385,641	12%	15%
MO	345,147,476	399,206,258	449,481,127	511,812,468	570,760,614	580,070,961	621,729,378	7%	10%
MS	21,044,052	32,530,467	58,524,672	87,631,259	95,938,167	132,325,334	141,184,370	7%	40%
MT	60,696,538	70,340,045	78,382,219	85,252,663	88,122,144	97,642,250	103,983,813	6%	9%
NC	463,609,045	558,075,236	592,558,621	708,833,976	738,980,537	803,020,762	943,129,577	17%	13%
ND	43,787,296	49,531,352	52,597,980	57,422,566	60,710,662	71,566,122	75,530,923	6%	10%
NE	100,011,740	121,727,696	145,614,364	150,870,672	181,539,948	195,652,635	205,391,629	5%	13%
NH	124,053,331	126,288,174	139,927,822	146,442,215	153,023,854	157,268,040	160,925,054	2%	4%
NJ	537,005,449	558,205,043	604,818,677	630,458,367	708,277,785	717,331,965	760,659,698	6%	6%
NM	121,122,907	139,520,928	209,851,453	315,871,472	386,869,438	443,840,549	422,446,991	-5%	25%
NV	19,999,536	26,912,584	39,621,561	55,810,256	61,185,626	68,883,810	73,281,681	6%	25%
NY	3,826,403,539	3,962,425,751	4,283,831,284	4,649,300,029	5,221,679,045	6,383,265,802	6,994,885,180	10%	11%
OH	409,361,603	474,154,911	393,421,441	631,433,786	890,302,433	979,106,140	1,079,937,061	10%	20%
OK	205,068,002	231,706,553	286,103,374	333,223,397	336,358,287	317,825,224	355,883,819	12%	10%
OR	346,481,134	425,896,091	481,431,288	545,858,372	573,651,105	561,005,749	586,982,775	5%	9%
PA	626,666,677	735,018,352	927,575,342	1,151,315,230	1,183,722,614	1,312,957,767	1,402,817,082	7%	15%
RI	115,326,442	171,123,778	188,876,938	190,088,897	234,349,883	242,920,957	243,358,671	0%	14%

	1999	2000	2001	2002	2003	2004	2005	04-05 % change	99-05 ave. % change
SC	166,177,132	196,655,802	219,147,679	258,992,320	251,018,445	276,384,268	289,973,671	5%	10%
SD	53,700,190	57,883,684	62,643,276	68,208,356	72,210,508	84,588,075	78,213,732	-8%	7%
TN	142,291,471	191,566,970	221,847,369	232,033,196	244,002,478	344,405,767	511,051,410	48%	25%
TX	996,324,778	1,052,417,524	1,250,884,507	1,219,590,440	1,285,929,840	1,725,338,259	1,948,858,899	13%	12%
UT	70,067,069	85,494,638	94,302,629	105,362,250	114,232,476	125,792,990	130,506,350	4%	11%
VA	218,233,875	247,890,100	283,226,518	331,032,037	363,474,313	361,373,278	428,205,981	18%	12%
VT	72,120,953	85,212,422	97,544,402	112,839,854	120,479,143	138,898,560	135,720,980	-2%	11%
WA	412,495,194	481,003,669	552,663,949	607,335,239	754,188,684	725,306,765	870,772,906	20%	14%
WI	482,343,383	511,203,312	553,114,838	688,550,636	805,316,425	902,982,327	986,359,055	9%	13%
WV	141,359,599	150,528,685	169,878,918	190,140,071	231,515,967	239,216,629	264,715,212	11%	11%
WY	46,503,408	49,853,111	53,182,977	62,468,635	76,935,975	82,799,192	84,337,828	2%	11%

Notes: Total Medicaid HCBS comprises Medicaid Home Health, Medicaid Personal Care Services and Medicaid 1915(c) HCBS waivers.

Table 2B: Medicaid Home Health Expenditures, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$2,112,094,893	\$2,280,401,216	\$2,472,456,345	\$2,679,309,142	\$2,764,719,769	\$4,102,673,737	\$4,422,756,428	8%
AK	736,927	708,268	718,783	582,373	847,971	745,169	842,140	13%
AL	22,267,560	21,603,923	22,111,550	21,798,128	9,200,000	11,500,000	16,000,000	39%
AR	14,030,833	12,355,265	11,527,798	10,096,036	9,850,412	12,639,824	13,140,257	4%
AZ	297,373,001	291,851,598	337,986,311	429,912,053	502,729,562	571,602,786	642,134,311	12%
CA	124,483,543	132,216,475	147,404,458	149,171,445	157,959,317	162,471,246	161,558,390	-1%
CO	60,380,594	67,351,024	81,976,321	85,568,256	96,765,246	99,363,747	102,730,227	3%
CT	120,335,835	130,897,232	147,822,566	159,091,638	179,555,091	173,256,410	178,419,015	3%
DC	4,109,948	4,061,100	2,793,585	10,469,694	12,151,247	12,477,553	12,900,296	3%
DE	7,045,021	5,422,921	5,429,135	3,407,683	12,425,477	3,578,162	3,699,391	3%
FL	19,822,613	23,067,203	27,649,025	36,225,117	44,679,843	53,740,571	67,040,745	25%
GA	14,797,553	11,584,279	10,622,527	14,315,705	13,535,479	7,417,488	6,663,172	-10%
HI	1,600,000	2,070,000	6,941,385	7,878,713	2,705,755	821,594	2,052,407	150%
IA	44,408,628	47,273,183	54,248,385	58,817,119	70,559,498	67,449,320	76,136,288	13%
ID	5,693,600	7,100,000	7,000,000	3,696,123	3,447,052	6,361,557	6,773,303	6%
IL	50,721,427	57,759,512	66,217,407	73,576,878	91,332,670	91,226,131	102,727,920	13%
IN	47,424,210	48,731,392	49,217,638	50,979,899	52,176,197	66,990,188	74,483,614	11%
KS	1,083,308	4,920,334	5,993,886	8,469,246	40,788,180	40,332,525	16,672,381	-59%
KY	62,506,928	75,034,667	80,392,026	73,973,550	58,123,840	54,133,985	52,478,633	-3%
LA	18,587,304	20,777,201	21,537,213	23,876,862	26,816,397	293,604,900	292,748,291	0%
MA	81,400,000	67,955,390	65,000,000	65,259,754	66,544,443	64,057,397	62,885,534	-2%
MD	49,100,000	52,100,000	58,100,000	3,039,841	2,633,317	2,522,558	2,690,828	7%
ME	15,704,936	10,731,156	6,883,316	6,957,632	5,567,061	5,894,201	6,093,899	3%
MI	11,061,281	7,852,083	7,945,699	6,591,733	4,775,925	4,824,999	4,514,608	-6%
MN	62,055,992	123,466,899	116,706,864	122,258,669	8,225,149	7,594,057	7,419,414	-2%
MO	8,096,906	8,228,555	7,810,903	4,990,941	6,133,801	5,339,312	7,112,690	33%
MS	6,188,836	7,116,857	10,915,766	13,005,819	14,697,688	28,883,417	19,289,258	-33%
MT	1,340,000	760,000	782,078	778,164	538,554	494,040	582,519	18%
NC	70,287,895	83,449,895	82,077,249	96,000,000	94,912,547	97,658,834	111,301,999	14%
ND	2,693,488	3,224,290	2,719,445	2,232,992	3,026,389	4,944,273	4,924,828	0%
NE	8,794,136	16,727,583	18,118,152	18,418,349	20,658,046	19,720,813	21,799,720	11%
NH	5,200,000	4,300,000	2,903,300	2,828,131	3,027,804	3,205,486	3,883,831	21%
NJ	75,455,240	55,742,434	49,068,815	35,800,000	3,096,136	37,590,995	38,864,591	3%
NM	1,943,102	1,849,000	1,638,000	1,082,000	537,793	314,941	385,628	22%
NV	2,500,000	3,000,000	6,174,866	5,619,075	6,135,552	6,300,314	6,513,771	3%
NY	575,984,205	607,673,981	634,792,137	660,137,875	704,235,427	1,342,916,050	1,424,463,030	6%
OH	24,011,401	48,600,238	38,695,248	38,713,335	114,662,541	132,313,455	136,313,372	3%
OK	1,265,559	923,562	1,008,937	1,253,470	4,157,614	5,411,159	7,741,957	43%
OR	459,711	674,325	693,000	983,876	4,251,443	1,033,097	1,068,099	3%
PA	34,274,108	32,602,401	72,998,756	131,801,491	37,158,631	45,277,198	52,370,294	16%
RI	5,650,676	3,956,975	3,337,686	3,033,322	3,114,110	3,631,995	3,755,048	3%
SC	14,346,335	13,006,344	12,124,148	18,000,000	3,184,390	18,900,500	19,540,856	3%
SD	4,078,450	4,091,645	3,893,210	3,954,763	3,256,255	4,152,611	4,293,303	3%
TN	13,534,588	16,728,506	18,846,241	21,999,779	33,818,209	69,345,932	136,076,374	96%
TX	69,766,962	90,961,338	113,319,229	152,357,543	176,893,893	414,932,713	459,641,627	11%
UT	3,741,527	4,024,093	4,875,634	1,469,759	2,908,401	8,801,033	9,216,678	5%
VA	7,063,036	6,698,293	5,306,165	5,002,239	4,434,208	3,052,856	4,555,784	49%
VT	4,351,705	6,932,113	7,508,491	5,081,326	4,534,280	8,008,774	8,280,115	3%
WA	5,642,994	4,807,752	4,586,418	4,448,191	3,843,462	3,235,696	4,488,692	39%
WI	25,225,578	24,146,040	22,155,252	20,600,315	18,232,274	18,721,877	19,356,181	3%
WV	2,365,565	2,149,068	2,902,982	2,536,393	18,643,742	2,663,283	2,753,516	3%
WY	1,101,847	1,134,822	978,359	1,165,848	1,231,450	1,216,714	1,377,602	13%

Source: Kaiser Commission and UCSF analysis of Medicaid Home Health Policy Survey

Table 2C: Medicaid Personal Care Services Expenditures, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$4,080,593,555	\$4,556,604,883	\$5,261,409,993	\$5,491,439,873	\$6,531,788,473	\$7,149,824,276	\$7,680,955,152	7%
AK	6,333,583	7,665,915	8,333,607	13,753,180	39,328,012	40,384,113	41,752,342	3%
AL								
AR	60,787,103	57,862,615	57,417,047	53,367,081	52,311,420	53,920,302	61,133,807	13%
AZ								
CA	1,198,264,831	1,486,198,331	1,792,437,265	1,800,000,000	2,300,000,000	2,605,215,000	2,857,270,000	10%
CO								
CT								
DC	9,422,005	9,918,300	10,976,890	6,320,357	10,283,304	10,559,448	10,917,206	3%
DE	0	0	0	0	0	0	0	0%
FL	10,326,059	11,473,399	12,748,241	34,647,505	35,127,374	35,264,090	33,411,364	-5%
GA								
HI								
IA								
ID	17,700,000	17,200,000	12,500,000	14,900,000	26,886,149	24,452,684	27,297,539	12%
IL								
IN								
KS								
KY								
LA								
MA	74,000,000	115,994,100	142,697,517	160,000,000	193,167,928	221,844,520	235,230,776	6%
MD	19,221,621	20,405,350	21,277,129	21,754,209	20,739,402	20,489,511	20,594,541	1%
ME	4,216,295	4,913,640	5,042,374	10,703,251	27,291,222	44,915,946	46,437,714	3%
MI	166,445,124	179,393,239	219,564,610	220,628,101	249,444,958	254,154,819	237,291,585	-7%
MN	106,332,005	117,182,849	129,754,550	131,834,917	116,529,285	121,767,212	180,595,587	48%
MO	105,092,223	125,674,924	147,261,072	182,245,807	209,162,473	211,888,818	239,480,611	13%
MS								
MT	17,627,260	19,201,331	20,348,283	23,929,583	21,300,000	21,900,000	23,400,000	7%
NC	73,963,864	92,949,966	113,353,293	153,829,363	190,808,485	221,038,726	286,650,908	30%
ND				1,960,000	2,004,233	4,555,927	5,314,206	17%
NE	2,902,471	5,950,259	6,091,183	6,812,003	8,115,824	8,463,093	9,784,319	16%
NH	2,554,884	2,900,000	685,648	797,312	653,552	498,912	510,956	2%
NJ	179,817,007	190,780,706	199,241,618	232,115,600	280,035,241	263,183,683	269,283,351	2%
NM		5,055,523	52,373,383	126,436,727	159,391,546	180,888,366	150,525,877	-17%
NV	2,429,592	2,920,105	4,827,331	16,519,023	19,808,910	20,340,852	21,030,007	3%
NY	1,464,026,040	1,520,556,019	1,571,618,449	1,709,273,337	1,796,653,275	1,930,721,116	2,045,068,149	6%
OH								
OK	28,447,513	35,202,700	40,016,361	29,000,000	31,000,000	31,832,464	32,910,959	3%
OR	862,382	1,556,635	2,157,480	2,408,250	3,099,567	4,496,546	5,644,782	26%
PA								
RI	0	0	0	0	0	0	0	0%
SC								
SD	855,128	845,252	1,195,058	1,174,155	1,321,017	1,336,531	1,336,705	0%
TN								
TX	377,362,681	382,120,135	509,872,132	315,237,716	374,444,269	417,972,927	459,179,146	10%
UT	292,587	476,609	580,856	661,353	846,589	1,271,532	1,082,312	-15%
VA								
VT				6,075,612	6,212,727	6,379,561	6,595,703	3%
WA	53,300,000	39,500,000	51,600,000	83,200,000	215,675,176	238,676,921	214,684,196	-10%
WI	69,296,679	74,353,907	100,696,997	105,597,753	113,296,271	123,839,364	128,035,086	3%
WV	28,714,618	28,353,074	26,741,619	26,257,678	26,850,264	27,571,292	28,505,417	3%
WY								

Notes: Personal care services are an optional benefit. In 2005, 30 states reported personal care services expenditures. Blank cells mean no program offered. Two states (DE and RI) were approved by CMS to offer personal care services but did not report expenditures during the period.

Source: Kaiser Commission and UCSF analysis of Medicaid Personal Care Services Policy Survey

Table 2D: Medicaid 1915(c) HCBS Waivers Expenditures, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$11,016,471,417	\$12,604,706,317	\$14,346,414,868	\$16,922,914,701	\$18,942,420,692	\$20,743,972,795	\$22,989,622,900	11%
AK	38,284,093	52,293,852	73,290,571	94,339,543	105,503,199	113,402,321	113,598,699	0%
AL	129,111,942	135,582,489	145,331,780	187,152,222	203,082,000	225,714,211	257,376,248	14%
AR	56,290,764	64,662,497	87,742,188	98,290,757	101,398,599	111,273,408	125,828,578	13%
AZ								
CA	550,073,070	582,303,528	777,815,395	974,812,364	1,140,538,550	1,256,949,711	1,368,841,987	9%
CO	209,560,648	277,436,411	304,367,008	337,123,586	362,571,513	364,644,248	358,434,542	-2%
CT	369,150,058	390,972,107	426,897,439	460,132,400	489,666,223	504,457,789	523,579,014	4%
DC	51,524	373,019	1,685,886	3,341,002	4,340,218	8,218,168	9,347,878	14%
DE	34,407,570	40,200,218	47,277,135	52,832,781	59,636,812	63,762,706	70,356,626	10%
FL	287,062,661	382,641,243	560,185,329	655,006,881	733,941,366	830,008,500	901,164,394	9%
GA	164,829,390	189,849,750	209,670,320	300,551,486	307,334,360	315,587,414	326,279,629	3%
HI	34,181,922	41,396,894	51,357,176	64,613,527	75,993,726	107,458,519	118,789,217	11%
IA	87,532,224	105,445,355	127,808,229	155,451,941	181,093,192	218,090,707	276,184,861	27%
ID	17,843,156	32,917,545	56,502,328	71,785,100	82,343,787	103,431,130	112,631,199	9%
IL	295,764,229	331,945,970	420,451,704	500,950,399	589,586,602	672,253,974	758,632,544	13%
IN	84,591,083	104,045,614	58,520,786	194,888,189	319,972,166	404,513,801	411,766,222	2%
KS	240,266,596	273,496,388	296,168,466	313,442,619	306,018,619	323,686,545	352,258,449	9%
KY	97,323,780	122,006,750	152,381,834	178,340,162	191,182,052	191,003,595	224,853,089	18%
LA	77,970,290	83,648,777	129,621,181	145,600,221	174,795,319	141,126,970	278,972,369	98%
MA	427,737,929	469,647,945	506,938,021	547,729,512	556,404,686	598,623,057	644,221,852	8%
MD	158,793,428	179,364,396	203,331,462	261,484,932	352,527,349	437,513,615	492,809,107	13%
ME	119,480,293	135,025,230	151,124,842	174,667,285	201,943,738	223,426,662	225,961,074	1%
MI	321,580,363	498,262,891	423,063,499	440,192,601	329,502,372	368,656,805	389,495,011	6%
MN	430,091,364	500,721,567	622,718,294	858,832,799	1,020,271,907	1,093,322,764	1,186,370,640	9%
MO	231,958,347	265,302,779	294,409,152	324,575,720	355,464,340	362,842,831	375,136,077	3%
MS	14,855,216	25,413,610	47,608,906	74,625,440	81,240,479	103,441,917	121,895,112	18%
MT	41,729,278	50,378,714	57,251,858	60,544,916	66,283,590	75,248,210	80,001,294	6%
NC	319,357,286	381,675,375	397,128,079	459,004,613	453,259,505	484,323,202	545,176,670	13%
ND	41,093,808	46,307,062	49,878,535	53,229,574	55,680,040	62,065,922	65,291,889	5%
NE	88,315,133	99,049,854	121,405,029	125,640,321	152,766,077	167,468,729	173,807,590	4%
NH	116,298,447	119,088,174	136,338,874	142,816,772	149,342,498	153,563,642	156,530,267	2%
NJ	281,733,202	311,681,903	356,508,244	362,542,767	425,146,408	416,557,287	452,511,756	9%
NM	119,179,805	132,616,405	155,840,070	188,352,745	226,940,099	262,637,242	271,535,486	3%
NV	15,069,944	20,992,479	28,619,364	33,672,158	35,241,164	42,242,644	45,737,903	8%
NY	1,786,393,294	1,834,195,751	2,077,420,698	2,279,888,817	2,720,790,343	3,109,628,636	3,525,354,001	13%
OH	385,350,202	425,554,673	354,726,193	592,720,451	775,639,892	846,792,685	943,623,689	11%
OK	175,354,930	195,580,291	245,078,076	302,969,927	301,200,673	280,581,601	315,230,903	12%
OR	345,159,041	423,665,131	478,580,808	542,466,246	566,300,095	555,476,106	580,269,894	4%
PA	592,392,569	702,415,951	854,576,586	1,019,513,739	1,146,563,983	1,267,680,569	1,350,446,788	7%
RI	109,675,766	167,166,803	185,539,252	187,055,575	231,235,773	239,288,962	239,603,623	0%
SC	151,830,797	183,649,458	207,023,531	240,992,320	247,834,055	257,483,768	270,432,815	5%
SD	48,766,612	52,946,787	57,555,008	63,079,438	67,633,236	79,098,933	72,583,724	-8%
TN	128,756,883	174,838,464	203,001,128	210,033,417	210,184,269	275,059,835	374,975,036	36%
TX	549,195,135	579,336,051	627,693,146	751,995,181	734,591,678	892,432,619	1,030,038,126	15%
UT	66,032,955	80,993,936	88,846,139	103,231,138	110,477,486	115,720,425	120,207,360	4%
VA	211,170,839	241,191,807	277,920,353	326,029,798	359,040,105	358,320,422	423,650,197	18%
VT	67,769,248	78,280,309	90,035,911	101,682,916	109,732,136	124,510,224	120,845,162	-3%
WA	353,552,200	436,695,917	496,477,531	519,687,048	534,670,046	483,394,148	651,600,018	35%
WI	387,821,126	412,703,365	430,262,589	562,352,568	673,787,880	760,421,086	838,967,787	10%
WV	110,279,416	120,026,543	140,234,317	161,346,000	186,021,962	208,982,054	233,456,279	12%
WY	45,401,561	48,718,289	52,204,618	61,302,787	75,704,525	81,582,478	82,960,226	2%

Notes: AZ does not operate a 1915(c) waiver because all HCBS are provided through a 1115 waiver.

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 3A: Total Medicaid HCBS Average Expenditures Per Person Served, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change	99-05 ave. % change
Total	\$9,033	\$9,433	\$10,332	\$10,534	\$11,009	\$12,029	\$12,627	5%	6%
AK	13,312	15,270	17,967	20,397	22,888	24,505	23,626	-4%	10%
AL	8,543	8,712	8,607	10,863	10,740	12,027	13,448	12%	8%
AR	3,413	3,638	4,293	4,700	4,882	5,235	5,822	11%	9%
AZ	11,285	10,254	10,843	12,683	13,835	15,012	16,168	8%	6%
CA	5,878	6,349	8,106	6,936	8,059	8,856	9,114	3%	8%
CO	9,980	11,918	11,896	12,326	13,665	13,540	13,460	-1%	5%
CT	12,371	12,669	13,555	15,967	17,587	17,172	17,539	2%	6%
DC	3,051	3,140	3,595	4,750	5,270	5,944	6,108	3%	13%
DE	15,302	16,560	16,850	17,262	20,833	18,969	20,395	8%	5%
FL	5,307	6,080	7,952	8,542	9,506	10,463	10,619	1%	13%
GA	6,920	8,249	7,837	9,395	9,013	8,548	8,603	1%	4%
HI	14,054	15,436	9,122	11,073	12,538	23,321	21,339	-9%	14%
IA	4,928	5,495	6,015	6,499	6,785	6,781	8,267	22%	9%
ID	6,582	6,528	7,184	8,404	8,653	8,482	8,869	5%	5%
IL	5,007	5,348	5,800	6,096	6,122	6,418	6,016	-6%	3%
IN	9,410	11,129	8,064	15,157	18,986	21,037	21,743	3%	20%
KS	13,272	13,074	13,516	13,224	13,687	13,110	12,629	-4%	-1%
KY	4,595	5,470	5,773	6,057	5,864	6,275	7,428	18%	9%
LA	6,655	5,517	9,651	10,416	11,042	21,858	26,467	21%	32%
MA	12,697	13,548	14,959	16,446	16,933	19,141	18,598	-3%	7%
MD	14,450	14,573	15,060	16,673	18,595	23,643	21,960	-7%	8%
ME	11,859	14,182	19,269	21,634	16,816	18,380	18,821	2%	10%
MI	7,580	9,795	8,737	8,925	7,390	7,861	7,973	1%	2%
MN	17,296	18,662	18,324	21,991	22,200	21,832	23,167	6%	5%
MO	4,843	5,176	5,597	6,112	6,813	6,550	6,967	6%	6%
MS	2,553	3,165	3,136	4,012	4,063	4,570	6,040	32%	16%
MT	9,725	10,815	12,000	12,715	13,505	13,370	13,758	3%	6%
NC	12,811	13,879	13,884	9,315	8,771	8,375	8,505	2%	-6%
ND	13,817	14,517	19,387	18,109	14,714	13,872	13,705	-1%	1%
NE	11,943	10,823	11,770	12,311	12,480	12,987	12,818	-1%	1%
NH	9,003	9,102	20,490	19,304	19,073	19,375	20,724	7%	21%
NJ	11,278	11,671	16,750	14,564	14,929	15,564	15,696	1%	7%
NM	15,992	15,298	26,959	27,460	25,585	27,858	26,303	-6%	12%
NV	6,911	8,163	7,937	9,242	8,850	9,575	9,864	3%	6%
NY	14,840	15,566	17,254	18,621	20,829	23,496	25,751	10%	10%
OH	6,779	5,872	6,208	8,478	6,653	6,800	7,913	16%	4%
OK	9,746	7,802	9,514	10,444	11,726	10,519	10,867	3%	3%
OR	10,298	11,252	11,496	11,982	12,908	12,831	13,155	3%	4%
PA	21,969	23,249	16,806	15,971	24,583	24,385	25,228	3%	5%
RI	13,693	23,112	21,308	31,477	38,387	38,370	37,052	-3%	21%
SC	5,488	6,594	7,432	8,197	8,093	8,855	9,223	4%	9%
SD	5,985	6,628	7,139	7,610	8,049	9,164	8,543	-7%	6%
TN	13,661	17,999	20,917	20,721	19,407	19,420	26,864	38%	13%
TX	5,504	4,889	5,037	4,528	4,160	5,916	6,129	4%	3%
UT	14,429	14,685	15,064	17,476	16,565	14,068	14,659	4%	1%
VA	9,649	11,419	13,819	16,062	17,793	17,597	18,835	7%	12%
VT	12,199	13,445	14,343	12,943	14,157	15,329	15,158	-1%	4%
WA	9,149	9,970	10,888	11,331	11,842	11,274	13,743	22%	7%
WI	11,600	12,263	14,023	14,567	16,386	17,090	18,228	7%	8%
WV	11,223	11,865	12,277	13,085	15,561	15,977	17,796	11%	8%
WY	18,483	19,123	18,096	18,993	21,863	22,803	21,319	-7%	3%

Notes: Total Medicaid HCBS comprises Medicaid Home Health, Medicaid Personal Care Services and Medicaid 1915(c) HCBS waivers.

Table 3B: Medicaid Home Health Average Expenditures Per Person Served, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$3,066	\$3,197	\$3,465	\$3,456	\$3,205	\$4,601	\$4,785	4%
AK	1,420	2,459	2,754	2,510	2,965	2,730	2,770	1%
AL	2,944	2,769	2,790	3,110	1,399	1,812	2,368	31%
AR	1,398	1,380	1,401	1,404	1,455	1,903	1,936	2%
AZ	11,285	10,254	10,843	12,683	13,835	15,012	16,168	8%
CA	1,246	1,461	1,814	1,917	1,766	1,867	1,856	-1%
CO	8,480	9,991	9,587	9,736	13,208	12,008	11,826	-2%
CT	4,673	4,963	5,553	7,185	8,578	8,079	8,202	2%
DC	1,468	1,449	1,189	5,157	5,721	5,875	6,074	3%
DE	6,290	5,506	5,064	3,446	12,564	3,618	3,741	3%
FL	1,340	1,625	1,930	2,367	2,557	2,692	3,163	18%
GA	1,586	1,503	1,453	1,622	1,240	566	475	-16%
HI	2,627	3,730	1,996	2,432	993	1,404	1,579	12%
IA	2,521	2,759	3,024	3,150	3,434	2,889	3,100	7%
ID	2,261	2,373	2,212	1,849	1,921	1,931	2,036	5%
IL	1,686	1,902	1,756	1,771	1,789	1,692	1,384	-18%
IN	4,892	5,544	6,036	5,522	6,336	7,494	8,389	12%
KS	751	1,739	2,308	3,118	6,099	5,639	2,843	-50%
KY	3,075	3,700	3,508	3,193	2,359	2,284	2,341	3%
LA	1,729	1,446	2,040	2,203	2,427	25,176	24,021	-5%
MA	3,131	2,718	2,843	3,234	3,409	3,883	3,518	-9%
MD	7,333	6,975	7,606	924	732	2,026	613	-70%
ME	2,261	1,946	2,128	2,281	1,773	2,050	2,120	3%
MI		1,894	1,665	1,152	575	681	687	1%
MN	7,359	13,013	13,122	15,519	1,590	1,420	1,419	0%
MO	1,350	1,318	1,293	733	848	737	919	25%
MS	1,184	1,262	1,397	1,401	1,420	1,986	2,184	10%
MT	1,365	927	1,370	1,441	1,181	1,044	1,333	28%
NC	6,591	7,200	6,583	2,955	2,858	2,723	2,878	6%
ND	2,797	2,953	10,581	10,893	3,769	5,500	9,453	72%
NE	3,212	3,845	3,765	3,547	3,688	3,565	3,465	-3%
NH	537	457	1,487	1,299	1,316	1,342	1,367	2%
NJ	5,228	4,318	10,806	3,503	303	3,679	3,803	3%
NM	462	409	3,091	2,222	883	805	895	11%
NV	7,143	7,500	4,250	3,862	3,956	4,062	4,200	3%
NY	5,188	5,877	6,788	7,120	7,838	12,108	13,039	8%
OH	905	1,058	1,179	1,110	1,276	1,372	1,616	18%
OK	397	270	278	336	1,383	1,409	1,509	7%
OR	608	759	403	438	1,894	460	476	3%
PA	2,960	3,791	3,021	3,623	4,604	4,937	5,596	13%
RI	1,751	2,192	1,172	3,033	3,114	3,632	3,755	3%
SC	1,399	1,404	1,374	1,622	287	1,703	1,760	3%
SD	744	785	823	836	689	878	908	3%
TN	2,434	2,918	3,356	3,492	4,422	5,480	10,852	98%
TX	894	872	875	970	947	2,428	2,457	1%
UT	3,296	2,937	3,303	1,936	1,955	3,975	4,345	9%
VA	1,108	1,111	1,068	1,120	1,157	1,056	1,381	31%
VT	1,395	2,119	2,224	1,480	1,295	2,218	2,293	3%
WA	1,429	1,373	1,201	1,304	1,190	1,132	1,248	10%
WI	3,352	3,151	3,275	3,333	3,089	3,172	3,279	3%
WV	1,455	1,298	1,626	1,450	10,660	1,523	1,574	3%
WY	2,599	2,639	2,055	2,268	2,203	2,270	2,438	7%

Source: Kaiser Commission and UCSF analysis of Medicaid Home Health Policy Survey

Table 3C: Medicaid Personal Care Services Average Expenditures Per Person Served, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$7,722	\$7,881	\$9,036	\$8,039	\$9,074	\$9,418	\$9,666	3%
AK	5,100	5,265	5,261	7,035	14,343	14,728	15,227	3%
AL								
AR	3,311	3,266	3,413	3,363	3,375	3,478	3,956	14%
AZ								
CA	6,777	7,023	8,815	6,344	7,986	8,830	9,103	3%
CO								
CT								
DC	5,802	6,104	6,657	3,696	4,372	4,490	4,642	3%
DE	0	0	0	0	0	0	0	0%
FL	1,212	1,212	1,212	2,342	2,396	2,396	2,390	0%
GA								
HI								
IA								
ID	8,060	8,954	6,857	6,613	7,962	6,766	7,581	12%
IL								
IN								
KS								
KY								
LA								
MA	19,903	20,472	20,568	17,778	18,275	18,935	17,087	-10%
MD	4,154	4,363	4,523	4,502	4,373	4,451	4,436	0%
ME	3,861	3,812	3,633	5,651	4,118	5,714	5,907	3%
MI	3,836	3,874	4,582	4,290	4,676	4,622	4,302	-7%
MN	14,953	16,015	16,693	17,564	18,491	14,620	18,169	24%
MO	2,873	3,206	3,582	4,145	4,665	4,298	4,840	13%
MS								
MT	6,375	6,872	6,957	7,987	7,437	7,324	7,490	2%
NC	8,141	8,273	8,949	5,684	5,602	5,274	5,641	7%
ND				4,356	4,454	5,863	3,902	-33%
NE	3,367	5,365	5,215	5,639	6,238	6,241	6,317	1%
NH	20,942	23,387	18,043	22,780	25,137	19,956	20,438	2%
NJ	9,126	9,265	12,740	14,128	15,815	13,861	12,894	-7%
NM		5,725	16,522	19,889	17,789	18,991	15,657	-18%
NV	4,948	6,504	6,072	11,005	9,720	9,981	10,319	3%
NY	16,344	17,126	17,785	20,138	21,428	22,552	24,268	8%
OH								
OK	4,619	4,711	5,708	2,900	4,429	4,547	4,702	3%
OR	682	752	806	1,254	1,305	1,000	1,110	11%
PA								
RI	0	0	0	0	0	0	0	0%
SC								
SD	965	850	1,177	1,111	1,393	1,448	1,484	2%
TN								
TX	5,577	5,437	6,552	5,055	5,591	5,856	5,908	1%
UT	1,617	1,708	1,827	1,900	1,881	712	617	-13%
VA								
VT				3,887	4,572	4,159	4,300	3%
WA	6,990	6,064	7,159	7,564	10,061	10,660	11,649	9%
WI	6,262	7,076	9,511	10,146	10,817	11,134	11,511	3%
WV	5,050	4,848	5,034	5,790	5,921	6,080	6,286	3%
WY								

Notes: Personal care services are an optional benefit. In 2005, 30 states reported personal care services expenditures. Blank cells mean no program offered. Two states (DE and RI) were approved by CMS to offer personal care services but did not report expenditures during the period.

Source: Kaiser Commission and UCSF analysis of Medicaid Personal Care Services Policy Survey

Table 3D: Medicaid 1915(c) HCBS Waivers Average Expenditures Per Person Served, by State, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	04-05 % change
Total	\$16,013	\$16,376	\$17,055	\$18,321	\$19,275	\$20,557	\$21,681	5%
AK	23,259	23,461	26,768	30,035	31,616	34,458	31,865	-8%
AL	12,714	13,239	12,604	15,306	15,397	16,872	18,964	12%
AR	5,617	6,213	7,665	8,656	9,025	9,410	10,372	10%
AZ								
CA	13,145	13,073	15,355	16,254	16,512	17,361	17,008	-2%
CO	10,516	12,503	12,722	13,218	13,792	14,027	14,015	0%
CT	26,721	26,383	27,055	27,654	28,602	27,993	28,655	2%
DC	1,777	2,590	5,601	6,709	7,174	10,509	9,799	-7%
DE	21,654	22,712	22,995	23,285	24,144	24,898	26,630	7%
FL	7,874	8,511	11,051	11,936	13,726	15,615	15,235	-2%
GA	9,914	11,358	10,079	12,175	12,450	12,784	13,217	3%
HI	17,647	18,309	17,630	19,533	21,401	26,481	27,226	3%
IA	9,561	9,894	10,367	10,872	10,948	11,623	15,293	32%
ID	11,504	8,546	10,104	11,040	10,490	11,598	11,715	1%
IL	7,564	7,810	9,103	9,506	9,799	10,338	11,002	6%
IN	19,509	21,070	11,241	27,885	28,152	30,022	30,537	2%
KS	14,351	14,811	14,989	14,493	16,409	15,702	15,087	-4%
KY	6,732	7,749	8,755	9,647	10,694	12,434	15,069	21%
LA	20,753	18,356	25,406	26,789	24,254	17,154	29,634	73%
MA	26,391	26,718	28,212	30,728	30,732	33,261	33,860	2%
MD	36,139	34,916	31,627	28,903	29,689	32,099	34,067	6%
ME	32,153	35,347	39,355	44,264	48,128	53,400	55,642	4%
MI	21,211	25,509	19,430	24,956	19,007	20,740	22,322	8%
MN	22,566	21,846	20,240	24,381	25,443	25,830	26,868	4%
MO	8,085	8,372	8,878	9,846	11,214	11,330	11,714	3%
MS	4,927	5,477	4,388	5,941	6,126	7,177	8,383	17%
MT	16,732	17,432	18,858	19,105	20,681	19,596	20,015	2%
NC	19,427	21,954	22,635	27,736	26,678	26,761	25,472	-5%
ND	18,628	19,960	20,309	21,156	19,380	17,820	17,997	1%
NE	18,499	17,113	18,993	21,462	19,985	20,480	21,240	4%
NH	29,272	27,421	28,181	26,576	26,214	26,927	31,951	19%
NJ	20,902	21,758	22,381	21,786	21,783	24,673	26,068	6%
NM	35,386	35,659	38,159	40,428	40,875	43,656	45,136	3%
NV	7,340	8,575	10,430	10,922	10,599	11,718	11,911	2%
NY	31,198	29,410	31,291	31,627	35,332	41,378	45,129	9%
OH	11,380	12,228	11,605	14,963	17,640	17,797	18,108	2%
OK	14,994	10,403	12,613	16,673	16,125	14,483	15,287	6%
OR	10,915	12,142	12,768	13,106	14,221	15,020	15,561	4%
PA	34,958	30,521	27,538	28,552	28,606	28,378	29,201	3%
RI	21,112	29,857	30,836	37,122	45,296	44,886	43,032	-4%
SC	7,582	8,933	10,019	11,759	12,443	12,802	13,295	4%
SD	18,706	20,952	18,989	19,855	20,532	22,107	20,591	-7%
TN	26,515	35,609	40,682	42,881	42,677	54,146	57,822	7%
TX	15,566	14,233	15,334	15,081	13,280	18,079	19,381	7%
UT	18,653	19,409	19,894	20,973	22,283	23,420	23,912	2%
VA	13,001	15,385	17,901	20,198	21,633	20,306	21,797	7%
VT	24,273	25,523	26,288	27,327	30,064	31,795	31,726	0%
WA	10,550	11,422	12,496	13,260	13,702	12,367	15,765	27%
WI	16,870	17,550	19,477	18,330	20,560	21,234	22,623	7%
WV	20,870	23,162	20,806	19,564	21,646	24,051	27,175	13%
WY	21,702	22,379	21,196	22,091	25,576	26,359	24,465	-7%

Notes: AZ does not operate a 1915(c) waiver because all HCBS are provided through a 1115 waiver.

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 4: National HCBS Waivers Participants, Expenditures, and Expenditures per Participant by Waiver Type, 2004 and 2005

Waiver Type	Participants			Expenditures (\$) (in thousands)			Expenditures per Participant (\$)		
	2004	2005	% Change	2004	2005	% Change	2004	2005	% Change
Total	1,009,106	1,060,356	5%	20,743,972	22,989,623	11%	20,557	21,681	5%
MR/DD	404,719	433,955	7%	15,442,186	17,060,670	10%	38,155	39,314	3%
Aged	103,363	109,313	6%	719,260	874,573	22%	6,959	8,001	15%
Aged/Disabled	403,663	415,315	3%	3,259,976	3,611,379	11%	8,076	8,696	8%
Physically Disabled	55,032	57,714	5%	780,220	857,504	10%	14,178	14,858	5%
Children	16,487	17,354	5%	187,920	189,330	1%	11,398	10,910	-4%
HIV/AIDS	14,242	14,258	0.1%	57,601	58,192	1%	4,044	4,081	1%
Mental Health	2,089	1,867	-11%	16,383	8,784	-46%	7,842	4,705	-40%
TBI/SCI	9,511	10,580	11%	280,428	329,190	17%	29,485	31,114	6%

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 5: Medicaid 1915(c) Waiver Participants, by Type of Waiver, 2005

	Number of Waivers	MR/DD	Aged	Aged/ Disabled	Physically Disabled	Children	HIV/AIDS	Mental Health	TBI/SCI	Total Participants
Total	272	433,955	109,313	415,315	57,714	17,354	14,258	1,867	10,580	1,060,356
AK	4	1,003	1,409		938	215				3,565
AL	5	5,199		7,816	557					13,572
AR	6	3,382	7,420	56	1,273					12,131
CA	6	62,613		13,911	1,074		2,882			80,480
CO	9	7,547		15,219		616	61	1,807	325	25,575
CT	5	6,350		11,079	596				247	18,272
DC	3	429		521			4			954
DE	4	729	211	1,101			601			2,642
FL	10	26,597	7,330	18,443		5	6,511		265	59,151
GA	5	8,479		15,418		166			623	24,686
HI	5	2,062		2,195		46	60			4,363
IA	6	11,171	5,764		504		42		579	18,060
ID	4	1,861		7,733					20	9,614
IL	7	11,953	29,089	3,021	19,721	530	1,637		3,002	68,953
IN	8	9,395		3,836		114			139	13,484
KS	6	6,746	7,706		6,487	2,169			240	23,348
KY	4	2,659		12,101	64				98	14,922
LA	5	4,620		3,729	280	785				9,414
MA	3	11,870	7,068						88	19,026
MD	6	9,663	3,284		430	1,077			12	14,466
ME	3	2,572		1,229	260					4,061
MI	3	7,911		9,144		394				17,449
MN	5	14,953	17,046		10,847				1,310	44,156
MO	7	8,119		23,233	584		88			32,024
MS	5	2,099		10,961	923				557	14,540
MT	3	2,144		1,853						3,997
NC	5	6,941		13,729		631	102			21,403
ND	3	3,102		497					29	3,628
NE	7	3,084		4,792		282			25	8,183
NH	4	2,191	2,590						118	4,899
NJ	6	9,598		6,691	224		559		287	17,359
NM	4	3,363		2,442		173	38			6,016
NV	4	1,306	2,016		518					3,840
NY	8	52,401		21,809		2,461			1,446	78,117
OH	7	14,097		30,560	7,453					52,110
OK	5	4,177		16,048		396				20,621
OR	5	8,984		28,222		85				37,291
PA	11	22,025	16,001		4,130	3,710	229		152	46,247
RI	6	2,780	690	1,992	106					5,568
SC	6	4,951		13,626	46		1,229		489	20,341
SD	4	2,533	915		77					3,525
TN	5	5,521		964						6,485
TX	9	12,991		38,801	142	1,212				53,146
UT	5	3,899	774		112	141			101	5,027
VA	5	6,797		12,056	368		215			19,436
VT	4	2,004		1,745				60		3,809
WA	7	10,194		31,139						41,333
WI	8	13,432		21,173		2,146			334	37,085
WV	2	3,649		4,942						8,591
WY	5	1,809		1,488					94	3,391

Notes: MR/DD is Mental Retardation/Developmentally Disabled, HIV/AIDS is Human Immunodeficiency Virus/
Acquired Immunodeficiency Syndrome and TBI/SCI is Traumatic Brain and Spinal Cord Injury.

Blank cell means state offers no waiver for that target group

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 6: Medicaid 1915(c) Waiver Expenditures by Type of Waiver, 2005

	Number of Waivers	MR/DD	Aged	Aged/ Disabled	Phys. Disabled	Children	HIV/ AIDS	Mental Health	TBI/ SCI	Total Exp.
(in thousands)										
Total	272	\$17,060,670	\$874,573	\$3,611,379	\$857,504	\$189,330	\$58,192	\$8,784	\$329,190	\$22,989,623
AK	4	63,010	27,613		14,861	8,114				113,599
AL	5	191,484		59,243	6,649					257,376
AR	6	75,645	34,955	422	14,807					125,829
CA	6	1,253,974		41,374	61,576		11,919			1,368,842
CO	9	244,072		96,423		440	447	8,076	8,976	358,435
CT	5	401,021		89,176	11,433				21,950	523,579
DC	3	5,490		3,858			0			9,348
DE	4	54,251	1,354	12,329			2,424			70,357
FL	10	632,731	129,335	122,810		36	10,970		5,283	901,164
GA	5	200,734		94,867		6,796			23,882	326,280
HI	5	77,905		38,637		1,931	316			118,789
IA	6	228,039	36,977		1,977		307		8,885	276,185
ID	4	51,425		60,095					1,111	112,631
IL	7	359,084	124,475	32,721	186,173	1,895	17,678		36,607	758,633
IN	8	374,792		32,236		1,315			3,424	411,766
KS	6	213,011	55,285		77,172	1,363			5,428	352,258
KY	4	159,994		52,668	5,665				6,526	224,853
LA	5	229,872		40,691	1,145	7,265				278,972
MA	3	611,852	27,327						5,042	644,222
MD	6	400,326	61,893		13,253	16,303			1,034	492,809
ME	3	202,463		16,638	6,860					225,961
MI	3	334,215		45,339		9,940				389,495
MN	5	843,115	140,785		141,780				60,691	1,186,371
MO	7	284,696		84,081	5,069		1,290			375,136
MS	5	37,147		68,353	10,270				6,125	121,895
MT	3	57,958		22,043						80,001
NC	5	275,338		242,949		25,102	1,788			545,177
ND	3	59,883		4,615					793	65,292
NE	7	111,619		50,224		11,124			841	173,808
NH	4	128,147	21,782						6,601	156,530
NJ	6	362,495		57,818	9,777		3,778		18,643	452,512
NM	4	216,393		49,992		4,776	375			271,535
NV	4	35,597	7,264		2,877					45,738
NY	8	3,411,391		28,929		21,838			63,196	3,525,354
OH	7	512,873		257,839	172,912					943,624
OK	5	208,491		104,062		2,677				315,231
OR	5	333,571		246,559		140				580,270
PA	11	1,058,667	192,389		78,731	12,734	1,028		6,898	1,350,447
RI	6	218,282	5,480	12,543	3,299					239,604
SC	6	173,692		78,522	957		5,112		12,150	270,433
SD	4	66,571	4,263		1,750					72,584
TN	5	369,578		5,397						374,975
TX	9	414,193		593,112	5,927	16,806				1,030,038
UT	5	111,875	3,396		1,747	1,208			1,980	120,207
VA	5	271,671		130,380	20,839		761			423,650
VT	4	92,221		27,916				708		120,845
WA	7	339,697		311,903						651,600
WI	8	454,426		326,982		37,527			20,033	838,968
WV	2	174,384		59,072						233,456
WY	5	71,307		8,564					3,090	82,960

Note: Blank cell means state offers no waiver for that target group.

Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 7: Medicaid 1915(c) Waiver Expenditures Per Person Served, by Type of Waiver, 2005

	Number of Waivers	MR/DD	Aged	Aged/ Disabled	Physically Disabled	Children	HIV/AIDS	Mental Health	TBI/SCI	Total Expenditures Per Person
Total	272	\$39,314	\$8,001	\$8,696	\$14,858	\$10,910	\$4,081	\$4,705	\$31,114	\$21,681
AK	4	62,822	19,598		15,844	37,740				31,865
AL	5	36,831		7,580	11,938					18,964
AR	6	22,367	4,711	7,534	11,632					10,372
CA	6	20,027		2,974	57,333		4,136			17,008
CO	9	32,340		6,336		715	7,320	4,470	27,619	14,015
CT	5	63,153		8,049	19,182				88,865	28,655
DC	3	12,797		7,404			42			9,799
DE	4	74,418	6,415	11,198			4,033			26,630
FL	10	23,790	17,645	6,659		7,275	1,685		19,935	15,235
GA	5	23,674		6,153		40,942			38,334	13,217
HI	5	37,781		17,602		41,968	5,275			27,226
IA	6	20,413	6,415		3,922		7,312		15,345	15,293
ID	4	27,633		7,771					55,562	11,715
IL	7	30,041	4,279	10,831	9,440	3,575	10,799		12,194	11,002
IN	8	39,893		8,403		11,534			24,633	30,537
KS	6	31,576	7,174		11,896	628			22,616	15,087
KY	4	60,171		4,352	88,513				66,588	15,069
LA	5	49,756		10,912	4,088	9,255				29,634
MA	3	51,546	3,866						57,300	33,860
MD	6	41,429	18,847		30,821	15,137			86,157	34,067
ME	3	78,718		13,538	26,384					55,642
MI	3	42,247		4,958		25,230				22,322
MN	5	56,384	8,259		13,071				46,329	26,868
MO	7	35,065		3,619	8,679		14,661			11,714
MS	5	17,698		6,236	11,126				10,997	8,383
MT	3	27,033		11,896						20,015
NC	5	39,668		17,696		39,781	17,531			25,472
ND	3	19,305		9,287					27,355	17,997
NE	7	36,193		10,481		39,447			33,639	21,240
NH	4	58,488	8,410						55,943	31,951
NJ	6	37,768		8,641	43,648		6,759		64,959	26,068
NM	4	64,345		20,472		27,604	9,870			45,136
NV	4	27,257	3,603		5,553					11,911
NY	8	65,102		1,326		8,874			43,704	45,129
OH	7	36,382		8,437	23,200					18,108
OK	5	49,914		6,484		6,761				15,287
OR	5	37,129		8,736		1,642				15,561
PA	11	48,067	12,024		19,063	3,432	4,488		45,380	29,201
RI	6	78,519	7,941	6,297	31,126					43,032
SC	6	35,082		5,763	20,798		4,159		24,847	13,295
SD	4	26,282	4,659		22,722					20,591
TN	5	66,940		5,599						57,822
TX	9	31,883		15,286	41,738	13,867				19,381
UT	5	28,693	4,388		15,601	8,569			19,607	23,912
VA	5	39,969		10,815	56,627		3,539			21,797
VT	4	46,018		15,998				11,798		31,726
WA	7	33,323		10,016						15,765
WI	8	33,832		15,443		17,487			59,978	22,623
WV	2	47,790		11,953						27,175
WY	5	39,418		5,755					32,869	24,465

Note: Blank cells mean state offers no waiver for that target group
Source: Kaiser Commission and UCSF analysis of CMS Form 372

Table 8: Financial Eligibility Criteria for Medicaid 1915(c) HCBS Waivers, by Type of Waiver, 2007

	MR/DD	Aged	Aged/ Disabled	Physically Disabled (As a percent of SSI)	Children	HIV/AIDS	Mental Health	TBI/SCI
AK	300%	300%		300%	300%			
AL	300%		100%	300%				
AR	300%	300%		300%				
CA	100%		100%	100%		100%		
CO	300%		300%		300%	300%	300%	300%
CT	300%		300%	300%				300%
DC	300%		300%			300%		
DE	250%	250%	250%			250%		
FL	300%	300%	300%	300%	300%	300%		300%
GA	300%		300%		300%			300%
HI	100%		100%		100%	100%		
IA	300%	300%		300%		300%		300%
ID	300%		300%					300%
IL	100%	100%	100%	100%	100%	100%		100%
IN	300%		100%		100%			100%
KS	300%	300%		300%	300%			300%
KY	300%		300%	300%				300%
LA	300%		300%		300%			
MA	100%	100%						100%
MD	300%	300%		300%	300%			300%
ME	300%		300%	300%				
MI	300%		300%	300%				
MN	300%	300%		300%				300%
MO	100%		100%	100%	100%	100%		
MS	300%		300%	300%				300%
MT	100%		100%					
NC	100%		100%		100%	100%		
ND	100%		100%					100%
NE	100%		100%		100%			100%
NH	100%	100%						100%
NJ	300%		300%		300%	300%		300%
NM	n/r		n/r		n/r	n/r		
NV	300%	300%	300%	300%				
NY	100%		300%		a			100%
OH	300%		300%					
OK	300%		300%					
OR	300%		300%		a			
PA	300%	300%		300%	300%	300%		300%
RI	300%	300%	300%	300%				
SC	300%		300%	300%	300%	300%		300%
SD	300%	300%						
TN	300%		300%					
TX	300%		300%	300%	300%			
UT	300%	300%		300%	300%			300%
VA	300%	300%	300%	300%		300%		
WA	300%		300%					
WI	300%		300%					300%
WV	300%		300%					
WY	300%		300%					300%

Notes: 300% of SSI = \$1,869 in 2007. a means waivers use limits > Medicaid eligibility. AZ and VT do not operate 1915(c) waivers because all HCBS are provided through a 1115 waiver

n/r - no response to survey. Blank cell means state operates no waiver for that target group.

Source: Kaiser Commission and UCSF analysis of Medicaid 1915(c) Waiver Policy Survey

Table 9: Medicaid HCBS Programs Cost Controls and Consumer Direction, 2007

		Home Health			Personal Care Services			Waivers ⁴	
		Financial Eligibility ¹	Limits ²	Consumer Direction ³	Financial Eligibility ¹	Limits ²	Consumer Direction ³	Limits ²	Consumer Direction ³
AK	CN, MN, E	S	Y	CN	S				
AL	CN, MN, E				C, S				
AR	CN, MN			CN	S				Y
AZ	CN, E	C	Y						
CA	CN		Y	CN, MN	S			C	Y
CO	CN	C	Y						
CT	CN, MN	C, S						C	Y
DC	CN, MN	S		CN	S			S	
DE	CN	S		CN, MN					
FL	CN, MN			E				C, S, G	Y
GA	CN, MN, E	S	Y						
HI	CN, MN, E								Y
IA	CN, MN	C	Y					C, S	Y
ID	CN, E			CN	S	Y		C	Y
IL	CN, MN, E								
IN	MN	S	Y					C, S, G	
KS	CN, MN, E							C, S, G	Y
KY	CN, MN, E	S						S	Y
LA	CN, MN, E							C	
MA	CN			CN, MN, E		Y			
MD	CN			CN	C, S			C, S	Y
ME	CN, MN, E			CN, MN, E		Y		C, S	Y
MI	CN, MN, E			MN		Y		C	Y
MN	CN, MN, E			CN, MN, E	C			C	Y
MO	CN			CN	S	Y			
MS	CN, E		Y					C, S	
MT	CN, MN, E	S		CN, MN, E		Y		C	
NC	CN, MN, E	S		CN, MN, E				C, G	Y
ND	CN, MN	C		CN, MN					
NE	CN, MN, E	C	Y	CN, MN	S	Y		C	Y
NH	CN, MN, E			CN, MN, E		Y			
NJ	CN, MN, E			CN, MN	S			C	
NM	CN, MN			CN		Y			
NV	CN, E			CN					Y
NY	CN, MN			MN				C	Y
OH	MN, E	S						C, G	Y
OK	CN			CN				C	Y
OR	CN			CN	S	Y		C	Y
PA	CN, MN, E							C, S, G	Y
RI	CN			CN, MN					Y
SC	CN		Y					C, S	
SD	CN	S		MN	S			C, S	Y
TN	CN, MN, E								
TX	MN, E	S	Y	CN	S			C, G	Y
UT	CN, MN			CN, MN	S			C	Y
VA	CN, MN, E								Y
VT	CN, MN			CN					
WA	CN, MN, E			CN				C	Y
WI	CN, MN		Y	CN				C, G	Y
WV	CN, MN, E			CN, MN	S				
WY	CN, E							C	Y

Notes: 1: CN – Categorically Needy, MN – Medically Needy, E – EPSDT; 2: C – Cost Limits, S – Service/Hourly Limits, G – Geographical limit; 3: Y – Yes, consumer direction is required or allowed; 4: Financial eligibility of waivers are presented in Table 8.

Source: Kaiser Commission and UCSF analysis of Medicaid 1915(c) Waiver, Home Health and Personal Care Services Policy Survey

Table 10: Waiting Lists for Medicaid 1915(c) Home and Community-Based Service Waivers, By Enrollment Group, 2007

	MR/DD	Aged	Aged/ Disabled	Physically Disabled	Children	HIV/ AIDS	Mental Health	TBI/ SCI	Total
Total No. of Waivers	100	21	62	28	27	15	1	23	277
Enrollment Slots	508,031	155,642	463,726	60,736	16,735	20,419	1,900	12,750	1,239,939
No. of Wait Lists	52	3	22	11	9	0	0	9	106
Wait Lists that Screen for Eligibility (% of wait lists)	34 (65%)	2 (67%)	19 (86%)	8 (73%)	6 (67%)	0 (n/a)	0 (n/a)	7 (78%)	76 (72%)
Wait Lists that Prioritize Certain Clients (% of wait lists)	35 (67%)	1 (33%)	14 (64%)	5 (45%)	2 (22%)	0 (n/a)	0 (n/a)	7 (78%)	64 (63%)
Wait Lists Providing Non-Waiver Services (% of wait lists)	47 (90%)	1 (33%)	18 (82%)	8 (73%)	7 (78%)	0 (n/a)	0 (n/a)	8 (89%)	89 (84%)

Notes: Enrollment group and enrollment slots data reported or estimated for 277 of the total waivers in 2007. Waiting list data reported for 277 waivers in 2007. n/a - not applicable.

Source: Kaiser Commission and UCSF analysis of Medicaid 1915(c) Waiver Policy Survey

**Table 11: Waiting Lists for Medicaid 1915(c) HCBS Waivers,
by State and by Enrollment Group, 2007**

	MR/DD	Aged	Aged/ Disabled	Physically Disabled	Children	HIV/ AIDS	Mental Health	TBI/ SCI	Total
No.	52	3	22	11	9	0	0	9	106
AK	1,500	0		0	0				1,500
AL	unknown		1,785	200					1,985
AR	876	0		0					876
CA	0		1,200	742		0			1,942
CO	0		n/r		n/r	0	0	n/r	0
CT	1,730		0	71				0	1,801
DC	0		0			0			0
DE	0	0	0			0			0
FL	20,200	0	7,410	0	3	0		434	28,047
GA	10,364		763		n/r			115	11,242
HI	0		100		0	0			100
IA	1,215	0		n/r		n/r		n/r	1,215
ID	0		0					0	0
IL	0	0	0	0	0	0		0	0
IN	32,927		1,299		704			169	35,099
KS	1,435	0		0	0			n/r	1,435
KY	2,753		0	0				135	2,888
LA	7,487		9,209		4,913				21,609
MA	0	0						0	0
MD	0	6,000		1,200	1,200			0	8,400
ME	122		0	107					229
MI	n/r		3,404		600				4,004
MN	unknown	0		unknown				unknown	unknown
MO	0		0	39	0	0			39
MS	n/r		n/r	n/r				n/r	n/r
MT	1,372		600						1,972
NC	0		unknown		75	0			75
ND	0		0					0	0
NE	0		0		n/r			n/r	0
NH	0	0						0	0
NJ	0		0		n/r	0		50	50
NM	n/r		n/r		n/r	n/r			n/r
NV	540	343	0	145					1,028
NY	0		0		0			0	0
OH	44,666		2,107						46,773
OK	3,315		0						3,315
OR	3,528		0		0				3,528
PA	20,460	0		0	0	0		0	20,460
RI	0	0	99	12					111
SC	1,086		4,642	0	387	0		250	6,365
SD	23	0							23
TN	2,316		0						2,316
TX	50,515		36,390	22	8,166				95,093
UT	1,654	0		62	51			82	1,849
VA	9,334	0	0	0		0			9,334
WA	365		0						365
WI	3,948		11,777					270	15,995
WV	303		0						303
WY	113		210					0	323
Total	224,147	6,343	80,995	2,600	16,099	0	0	1,505	331,689
Ave. wait mth.	25	9	12	14	26	0	0	13	19

Notes: n/r - no response to survey wait list question. Unknown – state responds that there was a wait list but the number of persons on list is unknown. Blank cell means state operates no waiver for that target group. Source: Kaiser Commission and UCSF analysis of Medicaid Home Health and Personal Care Services Policy Survey

**Table 12: Medicaid Home Health and Personal Care Services
Provider Reimbursement Rates, 2007**

		Home Health(\$) ¹		Personal Care Services(\$) ²	
	Agency	Registered Nurse	Home Health Aide	Agency	Provider
AK	167.14				
AL	27/hour				
AR		112.60			13.84
AZ			9.15/hour		
CA				9.44	10.84
CO		94.63	32.99		
CT		91.52/hour	23.72/hour		
DC	75.00	60.00	17.80/hour	17.80	14.50
DE		137.84/hour	28.72/hour	19.00	
FL	24.25			9.70	
GA	60.21	60.21	60.21		
HI					
IA		82.70	32.60		
ID		209.80	127.00	15.38	
IL			61.34		
IN	21.76	31.80/hour	15.88/hour		
KS		45.00	23.50		
KY		87.15	34.10		
LA		34.00/hour	24.38		
MA		86.99	24.40/hour		12.28
MD		113	53.00	33.31/day	33.31/day
ME	84.95	25.00/hour	9.50/hour	14.27	8.26
MI	80.98	80.98	51.70	9.19	7.30
MN	68.26			15.24	
MO	63.27	63.27	63.20	16.00	
MS		129.74	42.17		
MT	65.41			15.20	
NC		108.31	49.55	14.80	
ND	78.54	78.54	78.54	18.72	13.00
NE	78.73	35.30/hour	19.90/hour		8.39
NH		82.92/hour	22.96/hour	17.52	
NJ		116.56/hour	24.88/hour	16.00	
NM	328.71/mth			13.16	9.50
NV		39.79/hour	32.85/hour	17.76	
NY		113.12/hour	28.76/hour	18.83	
OH	74	89.20	42.00		
OK	53.21	73.25	33.17		
OR		62.85	29.49	18.48	9.32
PA	60.50	35.00/hour	40.00		
RI	64.00	64.00		19.46	
SC		71.37	37.13		
SD		47.84/hour	30.92/hour	14.20	
TN					
TX	10.06/hour			7.30/visit	6.40/visit
UT	14.00/hour			14.00	
VA	125.41	114.15	72.67		
VT					
WA		87.43	45.32	16.62	10.25
WI		32.21/hour	39.70		
WV					
WY	50.00				
Ave. pay rate		\$71.98³	\$79.95	\$38.95	\$15.89
					\$12.09

Notes: 1: Pay rate is per visit unless otherwise noted; 2: Pay rate is per hour unless otherwise noted; 3: Average does not include NM as state does not report standardized average pay rate.

Source: Kaiser Commission and UCSF analysis of Medicaid Home Health and Personal Care Services Policy Survey

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This report (#7720-02) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery, Alabama 36103-5624

Submission Date: September 21, 2007

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

The Alabama Medicaid Agency is requesting a five year renewal of the Home and Community Based Waiver for the Elderly and Disabled Waiver #0068.91.R4.

State:	Alabama
Effective Date	October 1, 2008

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

State:	Alabama
Effective Date	October 1, 2008

Application: 1

Application for a §1915(c) HCBS Waiver
HCBS Waiver Application Version 3.3 – Post October 2005

1. Request Information

A. The State of **Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (optional): **Elderly and Disabled Waiver**

C. Type of Request (select only one):

☐	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
☐	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
☒	Renewal (5 Years) of Waiver #	0068.R05.01	
☐	Amendment to Waiver #		

D. Type of Waiver (select only one):

☐	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
☒	Regular Waiver, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date:

E.2 Approved Effective Date (CMS Use): **October 1, 2008**

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

☐	Hospital (select applicable level of care)
☐	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
☐	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☒	Nursing Facility (select applicable level of care)
☐	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
☐	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

State:	Alabama
Effective Date	October 1, 2008

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Application for a §1915(c) HCBS Waiver
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G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
☐	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
☒	Not applicable		

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Elderly and Disabled Waiver Program is to provide home and community-based services to elderly and disabled individuals in the community who would otherwise require nursing facility care. The waiver is aimed at providing quality and cost-effective services to individuals at risk of institutional care. The AMA serves as the administering agency for this program and the two operating agencies are the Alabama Department of Public Health and the Alabama Department of Senior Services. The operating agencies are 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 services workers, and making sure all direct service providers meet the qualifications. Anyone interested in waiver services should contact one of the operating agencies. The services provided under this waiver are case management, personal care, homemaker services, respite care (skilled and unskilled), companion services, adult day health and home delivered meals. The goal of the waiver is to help recipients receive services not ordinarily covered by Medicaid under the State Plan.

State:	Alabama
Effective Date	October 1, 2008

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- | | |
|----------------------------------|--|
| ☐ | The waiver provides for participant direction of services. <i>Appendix E is required.</i> |
| ☒ | Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i> |
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

☐	Yes
☒	No
☐	Not applicable

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- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

☐	Yes (<i>complete remainder of item</i>)
☒	No

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

☐	Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
☐	Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 - Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for 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 in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

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participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

During the course of this waiver period no further requests for changes have been received from the public. Recipient comments are gathered by the AMA Quality Improvement Standards Division and are given serious consideration in developing waiver improvements.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60

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days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Ginger
Last Name	Wettingfeld
Title:	Administrator
Agency:	Alabama Medicaid Agency
Address 1:	501 Dexter Avenue
Address 2:	
City	Montgomery
State	Alabama
Zip Code	36103
Telephone:	334-242-5018
E-mail	Ginger.Wettingfeld@medicaid.alabama.gov
Fax Number	334-353-4182

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____
State Medicaid Director or Designee

Date: _____

First Name:	Carol H.
Last Name	Steckel
Title:	Commissioner
Agency:	Alabama Medicaid Agency
Address 1:	501 Dexter Avenue
Address 2:	
City	Montgomery
State	Alabama
Zip Code	36103
Telephone:	334-242-5600
E-mail	Carol.Steckel@medicaid.alabama.gov
Fax Number	334-242-5097

State:	Alabama
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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

--

State:	Alabama
Effective Date	October 1, 2008

Attachment #1 to Application: 1

Appendix A: Waiver Administration and Operation
HCBS Waiver Application Version 3.3 – Post October 2005

Appendix A: Waiver Administration and Operation

- 1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

☐	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one; do not complete Item A-2</i>):
☐	The Medical Assistance Unit (<i>name of unit</i>):
☐	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>)
☒	The waiver is operated by Alabama Department of Public Health (ADPH) and Alabama Department of Senior Services (ADSS) a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-2.</i>

- 2. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Elderly and Disabled Waiver (E&D) is administered by the Long Term Care Division of the Alabama Medicaid Agency (AMA) and operated by ADPH and ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, (3) Conducts annual training to disseminate policies, rules and regulations regarding the home and community-based waiver programs and, (4) signs all qualified direct service providers contracts enrolled with ADPH and ADSS to provide waiver services.

The AMA Long Term Care (LTC) Waiver Quality Assurance Unit has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by any of the following sources; reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; and (4) Collect data and submit quarterly and annual reports to the Department of Public Health, Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

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The AMA LTC Waiver Quality Assurance Unit mails satisfaction surveys to clients on a quarterly basis, and tracks any complaints and/or grievances that are received.

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one*):

☐	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
☒	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*check each that applies*):

☐	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>
☐	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>
☒	Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	X	☐	☐
Assist individuals in waiver enrollment	☐	X	☐	☐
Manage waiver enrollment against approved limits	X	X	☐	☐
Monitor waiver expenditures against approved levels	X	X	☐	☐
Conduct level of care evaluation activities	☐	X	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	X	☐	☐
Perform prior authorization of waiver services	☐	☐	☐	☐
Conduct utilization management functions	X	X	☐	☐
Recruit providers	X	X	☐	☐
Execute the Medicaid provider agreement	X	X	☐	☐
Determine waiver payment amounts or rates	X	X	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	X	☐	☐

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Appendix B: Participant Access and Eligibility
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Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
☒	Aged or Disabled, or Both (select one)			
☒	Aged or Disabled or Both – General (check each that applies)			
	☒ Aged (age 65 and older)	0		☒
	☒ Disabled (Physical) (under age 65)	0		
	☒ Disabled (Other) (under age 65)	0		
☐	Specific Recognized Subgroups (check each that applies)			
	☐ Brain Injury			☐
	☐ HIV/AIDS			☐
	☐ Medically Fragile			☐
	☐ Technology Dependent			☐
☐	Mental Retardation or Developmental Disability, or Both (check each that applies)			
	☐ Autism			☐
	☐ Developmental Disability			☐
	☐ Mental Retardation			☐
☐	Mental Illness (check each that applies)			
	☐ Mental Illness (age 18 and older)			☐
	☐ Serious Emotional Disturbance (under age 18)			

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The E&D Waiver requires all clients to meet the nursing facility level of care.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

☒	Not applicable – There is no maximum age limit
☐	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (specify):

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Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

☒	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
☐	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
	☐	% , a level higher than 100% of the institutional average	
	☐	Other (<i>specify</i>):	
☐	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
☐	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
	The cost limit specified by the State is (<i>select one</i>):		
	☐	The following dollar amount: \$	
		The dollar amount (<i>select one</i>):	
	☐	Is adjusted each year that the waiver is in effect by applying the following formula:	
	☐	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	
	☐	The following percentage that is less than 100% of the institutional average:	
			%
	☐	Other – <i>Specify</i> :	

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- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	9205
Year 2	9205
Year 3	9205
Year 4 (renewal only)	9205
Year 5 (renewal only)	9205

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

☒	The State does not limit the number of participants that it serves at any point in time during a waiver year.
☐	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

☒	Not applicable. The state does not reserve capacity.	
☐	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
		Purpose:
		Purpose:
	Waiver Year	Capacity Reserved
	Year 1	
	Year 2	
	Year 3	
	Year 4 (renewal only)	
	Year 5 (renewal only)	

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

☒	The waiver is not subject to a phase-in or a phase-out schedule.
☐	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.** *Select one:*

☒	Waiver capacity is allocated/managed on a statewide basis.
☐	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is prioritized based on the imminent need for services that is determined through an assessment process or on the date of application or referral.

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **State Classification.** The State is a (*select one*):

☒	§1634 State
☐	SSI Criteria State
☐	209(b) State

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
☐	Low income families with children as provided in §1931 of the Act
☒	SSI recipients
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☒	Optional State supplement recipients
☐	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
☐	100% of the Federal poverty level (FPL)
☐	% of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐	Medically needy
☒	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :
	Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.135, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals eligible under 42 CFR 435.145 and 435.227.
<i>Special home and community-based waiver group under 42 CFR §435.217</i> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
☐	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
☒	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>

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	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
X	A special income level equal to (select one):		
	X	300% of the SSI Federal Benefit Rate (FBR)	
	☐	100 %	of FBR, which is lower than 300% (42 CFR §435.236)
	☐	\$	which is lower than 300%
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
☐	Aged and disabled individuals who have income at: (<i>select one</i>)		
	☐	100% of FPL	
	☐	%	of FPL, which is lower than 100%
	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

☐	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):		
	☐	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>	
	☐	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>	
☒	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>		

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

- b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State.** The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
☒	The following standard included under the State plan (<i>select one</i>):		
	☐	SSI standard	
	☐	Optional State supplement standard	
	☐	Medically needy income standard	
	☐	The special income level for institutionalized persons (<i>select one</i>):	
	☐	300% of the SSI Federal Benefit Rate (FBR)	
	☐	%	of the FBR, which is less than 300%
	☐	\$	which is less than 300%.
	☐	%	of the Federal poverty level
☒	Other (specify):		
	The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.		

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☐	The following dollar amount: \$	If this amount changes, this item will be revised.
☐	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
☐	SSI standard	
☐	Optional State supplement standard	
☐	Medically needy income standard	
☐	The following dollar amount: \$	If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:	
☒	Not applicable (see instructions)	
iii. Allowance for the family (select one):		
☐	AFDC need standard	
☐	Medically needy income standard	
☐	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:	
☐	Other (specify):	
☒	Not applicable (see instructions)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
	Not applicable (see instructions)	
☒	The State does not establish reasonable limits.	
☐	The State establishes the following reasonable limits (specify):	

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- c-1. Regular Post-Eligibility: 209(b) State.** The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one)</i> :			
	The following standard included under the State plan <i>(select one)</i>		
☐	The following standard under 42 CFR §435.121:		
	☐ Optional State supplement standard		
	☐ Medically needy income standard		
	☐ The special income level for institutionalized persons <i>(select one)</i>		
		☐ 300% of the SSI Federal Benefit Rate (FBR)	
		%	of the FBR, which is less than 300%
		\$	which is less than 300% of the FBR
		%	of the Federal poverty level
		Other (specify):	
☐	The following dollar amount:	\$	If this amount changes, this item will be revised.
☐	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only <i>(select one)</i> :			
☐	The following standard under 42 CFR §435.121		
☐	Optional State supplement standard		
☐	Medically needy income standard		
☐	The following dollar amount:	\$	If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:		
	Not applicable <i>(see instructions)</i>		
iii. Allowance for the family <i>(select one)</i>			
☐	AFDC need standard		
☐	Medically needy income standard		

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☐	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:
☐	Other (specify):
☐	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
☐	Not applicable (<i>see instructions</i>)
☐	The State does not establish reasonable limits.
☐	The State establishes the following reasonable limits (<i>specify</i>):

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b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
The following standard included under the State plan <i>(select one)</i>			
	☐	SSI standard	
	☐	Optional State supplement standard	
	☐	Medically needy income standard	
	☐	The special income level for institutionalized persons <i>(select one):</i>	
	☐	300% of the SSI Federal Benefit Rate (FBR)	
	☐	%	of the FBR, which is less than 300%
	☐	\$	which is less than 300%.
	☐	%	of the Federal poverty level
	Other (specify):		
☐	The following dollar amount: \$ If this amount changes, this item will be revised.		
☐	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only <i>(select one):</i>			
☐	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
Specify the amount of the allowance:			
☐	SSI standard		
☐	Optional State supplement standard		
☐	Medically needy income standard		
☐	The following dollar amount:	\$	If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:		
	Not applicable <i>(see instructions)</i>		
iii. Allowance for the family <i>(select one):</i>			

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☐	AFDC need standard
☐	Medically needy income standard
☐	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:
☐	Other (<i>specify</i>):
Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
☐	Not applicable (<i>see instructions</i>)
The State does not establish reasonable limits.	
☐	The State establishes the following reasonable limits (<i>specify</i>):

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
The following standard included under the State plan (<i>select one</i>)			
☐	☐	The following standard under 42 CFR §435.121:	
	☐	Optional State supplement standard	
	☐	Medically needy income standard	
	☐	The special income level for institutionalized persons (<i>select one</i>)	
	☐	300% of the SSI Federal Benefit Rate (FBR)	
	☐	%	of the FBR, which is less than 300%
	☐	\$	which is less than 300% of the FBR
☐	%	of the Federal poverty level	

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	Other (specify):	
☐	The following dollar amount:	\$ If this amount changes, this item will be revised.
☐	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
☐	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
☐	The following standard under 42 CFR §435.121:	
☐	Optional State supplement standard	
☐	Medically needy income standard	
☐	The following dollar amount:	\$ If this amount changes, this item will be revised.
☐	The amount is determined using the following formula:	
☐	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (select one)		
☐	AFDC need standard	
☐	Medically needy income standard	
☐	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
☐	The amount is determined using the following formula:	
☐	Other (specify):	
☐	Not applicable (<i>see instructions</i>)	

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iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
☐	Not applicable (<i>see instructions</i>)
☐	The State does not establish reasonable limits.
☐	The State establishes the following reasonable limits (<i>specify</i>):

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d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant <i>(select one):</i>		
☐	SSI Standard	
☐	Optional State Supplement standard	
☐	Medically Needy Income Standard	
☐	The special income level for institutionalized persons	
☐	%	of the Federal Poverty Level
☐	The following dollar amount: \$	If this amount changes, this item will be revised
☐	The following formula is used to determine the needs allowance:	
☐	Other <i>(specify)</i> :	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one:</i>		
☐	Allowance is the same	
☐	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
☐	Not applicable <i>(see instructions)</i>	
☐	The State does not establish reasonable limits.	
☐	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	One
ii.	Frequency of services. The State requires <i>(select one)</i> :
☐	The provision of waiver services at least monthly
☒	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
	All clients are monitored through at least one monthly face-to-face visit by the case manager only. The monthly face-to-face visit is the minimum monthly contact. Monitoring of participants is conducted more frequently if there is a change in the participant's medical condition or if there is a change in the participant's environmental circumstances. The frequency of other waiver services is determined by the physician based upon the needs of the waiver participant and is specified on the participant's individual plan of care.

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one)*:

☐	Directly by the Medicaid agency
☒	By the operating agency specified in Appendix A
☐	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
☐	Other <i>(specify)</i> :

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The OA have Nurse Consultants on staff that perform the initial evaluations. They are Registered Nurses with a State of Alabama license.

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- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The E&D Waiver recipients must meet the nursing facility level of care. The tool used to determine the NF LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form. New admissions must meet two of the criteria listed in A-J while a re-admission must meet only one of the criteria listed in A-J. Supporting documentation must be submitted with the application.

The admission criteria is as follows:

- A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment.
- B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
- C. Nasopharyngeal aspiration required for the maintenance of a clear airway.
- D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
- E. Administration of tube feedings by naso-gastric tube.
- F. Care of extensive decubitus ulcers or other widespread skin disorders.
- G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.
- H. Use of oxygen on a regular or continuing basis.
- I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
- J. Comatose client receiving routine medical treatment.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

☒	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
☐	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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- f. Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided an individual Level of Care (LOC) evaluation. The case managers submit a Home and Community Based Waiver (HCBS-1) application to the nurse reviewer on staff at the Operating Agencies to evaluate and make the level of care determination. The nurse reviewers evaluate the application to make sure it is complete, supports the need for waivers services, establishes the risk of nursing home placement and the medical criteria is met and level of care is approved. The approval of the appropriateness of admission or continued eligibility is assessed from the documentation as per the HCBS-1 assessment tool and other documents which may include physician progress notes, and/or hospital records. A review not only includes meeting the level of care criteria as developed by the Alabama Medicaid Agency but also the assessment of the support systems within the home, the functional limitations of the recipient, the diagnosis and any factors that would place the recipient at risk of institutionalization. Medicaid may also assist with difficult LOC evaluations.

Once the application is approved it's entered electronically into the EDS/Medicaid system. If no problems are identified, EDS enters the approval in the AMA Long Term Care file and writes a waiver eligibility segment indicating the beginning and ending eligibility dates. Verification and acceptance will be returned overnight to ADPH and ADSS.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

☐	Every three months
☐	Every six months
☒	Every twelve months
☐	Other schedule (<i>specify</i>):

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

☒	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
☐	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Reevaluations of eligibility for the E&D Waiver must be completed every twelve months. This process is the same as the initial application packet which includes a new level of care, and plan of care. Reevaluations must be done on a timely basis so that services and payment will not be interrupted. Billing for Waiver services is bounced against the Waiver Service Long Term Care

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Benefit Plan, and if eligibility for Waiver Services is current, the claim is paid. If the reevaluation has not been accomplished in a timely manner and the eligibility is not current, the claim will deny. The Alabama Medicaid Agency will not back date reevaluations not received in a timely manner.

The case managers review the client's records monthly to determine the need for waiver services. Case Managers also keep a copy of the client's reevaluation dates in a tickler file to ensure timely reevaluations are accomplished.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and reevaluations are maintained for a minimum period of 3 years. The clients records are located at:

1. Direct Service Providers
2. Operating Agency Case Record

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Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

- i. informed of any feasible alternatives under the waiver; and*
 - ii. given the choice of either institutional or home and community-based services.*
- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice: being informed of feasible alternatives under the waiver.

As part of the assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision as to where the client's care will be received. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the client, both formal and informal, as well as those waiver services which may be available to meet the client's needs and those needs which cannot be met.

Freedom of Choice: being given the choice of either institutional or home and community based services.

Each waiver client must make a written choice for either institution or community care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

- b. Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained in the Operating Agency Case Record.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanic is the only significant Limited English proficiency population in the State of Alabama at 1.7%.

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Appendix C-1: Summary of Services Covered

- a. Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	X	
Homemaker	X	
Home Health Aide	☐	
Personal Care	X	
Adult Day Health	X	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	Skilled and Unskilled
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	
Companion Services	X	
Home Delivered Meals	X	Breakfast; Shelf Stable and Frozen Meals
Other Services (select one)		
X	Not applicable	
○	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (list each service by title):	

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a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
Extended State Plan Services (select one)		
X	Not applicable	
○	The following extended State plan services are provided <i>(list each extended State plan service by service title)</i> :	
a.		
b.		
c.		
Supports for Participant Direction (select one)		
○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.	
X	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	
Other Supports for Participant Direction <i>(list each support by service title)</i> :		
a.		
b.		
c.		

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- b. Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
☐	As an administrative activity. <i>Complete item C-1-c.</i>
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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Appendix C-2: General Service Specifications

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

☒	Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable): Background checks will be required for direct service provider employees who operate within the State of Alabama and who either provide direct services to the participant and/or who have access to client records. The state background checks will be conducted by the provider agency and will also include a reference check with previous employers and the Nurse/Aid Registry. Verification of investigations will be conducted during periodic audit reviews of the service providers by the OA.
☐	No. Criminal history and/or background investigations are not required.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

☐	Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
☒	No. The State does not conduct abuse registry screening.

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

☒	No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
☐	Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i>

- i. Types of Facilities Subject to §1616(e).** Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

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- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

--

- iii. Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
X	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i> (A) Services provided by relatives or friends may be covered only if relatives or friends meet the same qualifications as other direct care providers and are employed by an approved provider of service. Relatives who are providers of services cannot be a parent/guardian of a minor or spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be justification as to why the relative or friend is the provider of care and documentation in the case manager's file showing the lack of other qualified providers. (B) The strict controls to assure that payment is made to relatives or friends as providers in return for authorized services include the following:

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	1) The relative or friend must be employed by a Direct Service Provider (DSP) Agency. 2) Meet the qualifications outlined in the scope of service as any other personal care, respite, homemaker, or companion worker employed by a DSP agency. 3) Complete a service log reflecting the type of service provided including the number of hours of service, the date and time of service. 4) Have the client/or representative sign the service log at each visit. If the relative or friend normally acts as a representative another individual must sign the service log. 5) The service log is reviewed by a DSP supervisor at least once biweekly. 6) Supervisory visits to the participant's residence at 60 day intervals. 7) Direct on-site supervision of the DSP worker providing the authorized service at least once every 6 months and more frequently if warranted. 8) Monthly visits by the case managers to address client satisfaction with the provision of services and to question the client confidentially about the adequacy of the services received and their needs are met as well as to observe the client or friend as services are provided. (C) While each service may be offered by a relative the state will ensure that no conflict of interest will occur because the relative providing the direct service will not be involved in the development of the care plan or allowed to sign service logs which serve as documentation that the authorized services have been provided when the participant is unable to do so. When the primary care giver or authorized representative for the participant must also act as the direct service provider worker another individual must be assigned the aforementioned responsibilities as well as assume responsibility for any other functions which could potentially result in a conflict of interest. The case manager must be available during the monthly visits to observe the provision of the direct service by the guardian and question the participant confidentially about their satisfaction with those services.
○	Other policy. <i>Specify:</i>

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- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared; and mailed. After the package is returned it is reviewed for completeness of information. The OA will conduct an initial on-site visit to verify that the provider is in compliance with Medicaid Waiver standards and regulations before approval as a direct service provider is made. Every new provider is also required to attend a waiver training conducted by the OA.

When all information from the potential provider has been reviewed and verified, a financial amount is established and a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement of the Elderly and Disabled Waiver based on the OA's review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Case Management		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☒	Service is included in approved waiver. There is no change in service specifications.		
☐	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services. Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver clients			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The unit of service will be fifteen minutes (15) beginning on the date that the client is determined eligible for E/D Waiver Services. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Employed by ADPH or ADSS contract with the Area Agency on Aging to provide Case Management.
Specify whether the service may be provided by (check each that applies):		☐ Legally Responsible Person	☐ Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Social Worker	Social Work		Earned the degree from an accredited School of Social Work
Registered Nurse	State of Alabama		License must be current

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Bachelor of Arts or Bachelor of Science Degree	None	None	Preferably in a human services related field from an accredited college or university	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Social Worker	ADPH, and ADSS		Verified initially, and bi-annually thereafter	
Registered Nurse	State Board of Nursing ADPH and ADSS		Verified Annually Verified Bi-annually	
Bachelor of Arts or Bachelor of Science Degree	ADPH and ADSS		Verified initially	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

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Service Specification				
Service Title:	Personal Care			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
☒	Service is included in approved waiver. There is no change in service specifications.			
☐	Service is included in approved waiver. The service specifications have been modified.			
☐	Service is not included in the approved waiver.			
Service Definition (Scope):				
Personal Care services provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family. Personal Care Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
The unit of service will be fifteen (15) minutes of direct PC Service provided in the client's residence. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the client's plan of care. The amount of time authorized does not include the Personal Care Worker's transportation time to or from the client's residence, or the worker break or mealtime.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒	Agency. List the types of agencies:
			Medicare/Medicaid certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.	
Specify whether the service may be provided by <i>(check each that applies):</i>		NO	Legally Responsible Person	☒ Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Personal Care Worker	None	None	Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency. The Personal Care Worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training	

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			per calendar year is also required.
Registered Nurse or Licensed Practical Nurse (in supervisory capacity)	Current license from the State of Alabama.	None	Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Home Health Agency	ADPH ADSS		Verified initially and bi-annually thereafter.
Nursing Services	ADPH, ADSS		Verified initially and bi-annually thereafter.
Service Delivery Method			
Service Delivery Method (check each that applies):	N/A	Participant-directed as specified in Appendix E	☐ Provider managed

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Service Specification			
Service Title:	Homemaker		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☒	Service is included in approved waiver. There is no change in service specifications.		
☐	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.			
Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The unit of service will be fifteen (15) minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the Plan of Care. The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Contracted DSP Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.
Specify whether the service may be provided by <i>(check each that applies):</i>		☐ Legally Responsible Person	☒ Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Homemaker	None	None	Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The

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			workers must get a tuberculin skin test annually.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Homemaker	ADPH, ADSS	Verified initially and bi-annually thereafter	
Homemaker Supervisor	ADPH, ADSS	Verified initially and bi-annually thereafter	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	N/A	Participant-directed as specified in Appendix E	☐ Provider managed

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Service Specification			
Service Title:	Respite Care		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☒	Service is included in approved waiver. There is no change in service specifications.		
☐	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 2880 units per waiver year (October 1-September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Contracted certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.
Specify whether the service may be provided by (check each that applies):		☐ Legally Responsible Person	☒ Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Registered	State of Alabama	None	A RN currently licensed by the Alabama

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Nurse(RN) (Skilled Respite)			This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and have at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually.
Licensed Practical Nurse((LPN) (Skilled Respite)	State of Alabama		This service will be performed by a Licensed Practical Nurse with an active license from the Alabama State Board of Nursing and have at least two (2) years experience as a LPN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. The LPN must work under the supervision of an RN.
Respite Care Worker (Unskilled Respite)	None	None	This service will be performed by non licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision. Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker and submit to a program for testing, prevention and control of tuberculosis.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	ADPH, ADSS	Verified initially and bi-annually thereafter
Licensed Practical Nurse	ADPH, ADSS	Verified initially and bi-annually thereafter
Respite Care Worker	ADPH, ADSS	Verified initially and bi-annually thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	N/A	Participant-directed as specified in Appendix E	☐	Provider managed
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Service Specification			
Service Title:	Adult Day Health		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☐	Service is included in approved waiver. There is no change in service specifications.		
☒	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service. Adult Day Health is not an entitlement. It is based on the needs of the individual client.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒ Agency. List the types of agencies: Adult Day Health Center
	☐		
	☐		
Specify whether the service may be provided by <i>(check each that applies)</i> :	☐	Legally Responsible Person	☐ Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Director of Center	None	None	Have a high school diploma or equivalent; test for tuberculosis annually; and
Registered Nurse or Licensed Practical Nurse	Licensed by the Alabama Board of Nursing	None	At least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing. Must submit to a program for the testing, prevention, and

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			control of tuberculosis annually.
Adult Day Care Worker	Alabama Driver's License	None	Have a valid Alabama driver's license if transporting Adult Day Health clients; possess a valid, picture identification; all Adult Day Health Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Director of Center	ADPH, ADSS		Verified as Necessary
Registered Nurse or Licensed Practical Nurse	ADPH, ADSS		Verified as Necessary
Adult Day Care Worker	ADPH, ADSS		Verified as Necessary
Service Delivery Method			
Service Delivery Method (check each that applies):	N/A	Participant-directed as specified in Appendix E	☐ Provider managed

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Service Specification			
Service Title:	Companion Service		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☒	Service is included in approved waiver. There is no change in service specifications.		
☐	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client. Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The unit of service will be fifteen (15) minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The maximum number of units that can be authorized may not exceed four (4) hours daily. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the client.			
Provider Specifications			
Provider Category(s) (check one or both):	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Contracted DSP, certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☒
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			

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Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Companion Worker	None	None	Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program. All Companion Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Companion Worker Supervisor	ADPH, ADSS		Verified initially and bi-annually thereafter
Companion Worker	ADPH, ADSS		Verified initially and bi-annually thereafter
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	N/A	Participant-directed as specified in Appendix E	☐ Provider managed

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Service Specification			
Service Title:	Home Delivered Meals		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
☒	Service is included in approved waiver. There is no change in service specifications.		
☐	Service is included in approved waiver. The service specifications have been modified.		
☐	Service is not included in the approved waiver.		
Service Definition (Scope):			
Home Delivered Meals are provided to an eligible individual age 21 or older who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals. When specified in the Plan of Care, this service may include seven (7) or fourteen (14) frozen meals per week. A client may be authorized to receive seven (7) frozen meals plus seven (7) breakfast meals in lieu of fourteen (14) frozen meals. In addition, the service may include the provision of two (2) or more shelf-stable meals (not to exceed 6 meals per 6-month period) to meet emergency nutritional needs when authorized on the client's Plan of Care. During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the meals vendor will be required to maintain at a minimum, a sufficient inventory to operate all frozen meals delivery routes for two days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid – approved Disaster Meal Services Plan. This plan will provide frozen meal alternates in anticipation of possible power outages.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual client and the unit(s) of service needed will be specified in the Plan of Care. The unit of service is one (1) package of seven meals. Each package of meals consist of (7) frozen meals or seven (7) breakfast meals. At least one unit of frozen meals may be delivered once a week to a client's residence. Additionally, a second package of seven (7) frozen meals or seven (7) breakfast meals can be provided as indicated on the Plan of Care. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the client's residence.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	☐	Individual. List types:	☒
			Agency. List the types of agencies:
			Contracted Vendor
Specify whether the service may be provided by <i>(check each that applies):</i>	☐	Legally Responsible Person	☐
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			

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Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Registered Dietician	State of Alabama valid state license	None	Current dietician registration
Driver of delivery truck	Valid driver's license		Should receive initial and on-going training in the proper service, handling, and delivery of food.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Home Delivered Meals Providers	State of Alabama	Verified initially and monitored on an on-going basis.	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	☐	Participant-directed as specified in Appendix E	☐ Provider managed

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i>
☐	Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
☐	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i>
☐	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
☒	Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery
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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care
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- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
	Social Worker. <i>Specify qualifications:</i>
	Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work
	Other (<i>specify the individuals and their qualifications</i>):
	Case Managers with a Bachelor of Arts or a Bachelor of Science degree preferably in a human related field.

- b. **Service Plan Development Safeguards.** *Select one:*

☐	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>
	Services and supports to clients are monitored directly by case managers on a monthly basis or as needed and peer reviews are done on an annual basis by ADSS. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients. Annual desk reviews performed by the AMA LTC Waiver Quality Assurance Unit may include case management personnel files, client files, and visits to participants in their homes. The AMA LTC Waiver QA Unit will also conduct retrospective reviews.

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- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager, the client, family member or legal representative/other person designated by the client, meet to develop the plan of care. During the meeting, all parties may discuss the needs of the client; informal supports provided by the family and/or other community services to identify the gaps in support and are informed by the case manager of waiver services which may fill the gaps. Replacement services for these gaps will be addressed by the case manager of waiver services at this time. The participant decides which personal representative(s) will be involved in development of the plan of care.

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- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The plan of care is developed as a part of the initial assessment for all applicants for available waiver services and revised periodically as the needs of the recipient change.

The plan of care is monitored monthly during the case manager's face-to-face visit, at redetermination annually and more frequently if the client's condition warrants a modification of the plan of care. When a plan of care is revised the client/and or their family member or legal representative must be issued a written notice at least 10 days in advance of any adverse actions that may result from the change.

When a participant is approved for EDW services and the POC is implemented or when changes are made to the plan of care, the case manager is responsible for contacting the Direct Services Provider (DSP) to discuss and coordinate the provision of services included in the plan of care. The case manager will seek a verbal approval or refusal to provide waiver services from the DSP. If the DSP agrees to provide services the case manager completes a service authorization form and sends this to the DSP along with a copy of the waiver application. The case manager must ensure that services requested on the service authorization form include only those services authorized in the POC. The DSP is also forwarded information about the specific needs and desires of the client as well as the specific task to be performed. When the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP will contact the case manager to discuss authorization of additional services. Case managers are responsible for review and modification to the POC.

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the participant's safety are addressed in the development of the plan of care. Plans are individualized and should take into consideration the participant's rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed, the plan of care adjusted accordingly and evaluated for appropriateness.

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During the monthly visit the case manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the POC. The case manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered “highly” at risk the case manager may visit more often to monitor the situation to ensure the participant’s health and safety is not jeopardized. When a risk has been reported or identified, a home visit to monitor the health and safety of the client is required as soon as it can be arranged.

Additionally, DSP staff must visit the participant’s home as ordered in the POC. DSPs are trained and expected to observe and report any concerns about a participant’s health and welfare to the case manager and in writing to supervision of the DSP agency.

Direct Service Providers have policy/procedures established for serving clients in the event the assigned worker is unable to provide the service. As part of this back-up protocol the DSP’s are notified of high risk clients so that any participant designated by the case manager as at risk should be given first priority when service visits must be temporarily prioritized and/or reduced by the DSP.

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As the plan of care is developed the case manager discusses and documents the client’s freedom to choose a direct service provider from the list of approved contract providers that are qualified, available and willing to provide the services. The case manager present a list of all qualified providers listed in alphabetical order for all waiver services available in the area. At the initial visit, a written choice should be made for each waiver service that the client desires to access.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The AMA will conduct a random sample of all plans of care for persons receiving waiver services. The LTC Waiver Quality Assurance Unit reviews a sample of plans of care and related documents annually for providers. This assures that the clients that are receiving services under the waiver have a plan of care in effect for the period of time that the services were provided. This review ensures that the need for services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

A copy of the plan of care is maintained by the case managers, service provider and in the client’s home.

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- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

☐	Every three months or more frequently when necessary
☐	Every six months or more frequently when necessary
☒	Every twelve months or more frequently when necessary
☐	Other schedule (<i>specify</i>):

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- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

☐	Medicaid agency
☐	Operating agency
☒	Case manager
☐	Other (<i>specify</i>):
	Direct Service Provider and the client's home

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Appendix D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The plan of care is monitored and reassessed by the OA case manager at least once a month during the face to face visit. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients.

The client and or responsible person is encouraged to notify the case manager if services are not being provided as planned and if the client's needs or situation changes. The case manager identifies and promptly carries out needed changes in coordination with the client and or responsible person and other care providers. The plan of care is revised as needed to adapt to a client's changing needs.

Ongoing reviews, completed by the AMA LTC Waiver Quality Assurance Unit staff, monitor case managers' and clients' records for service implementation and adherence to the plan of care. These reviews also ensure that the plans of care are reviewed at least monthly during a face to face visit. During the review, incidents and complaints are reviewed to assure that they are addressed and resolved appropriately. LTC Waiver Quality Assurance staff may also visit clients in their homes to assure that health and safety standards are being met.

- b. Monitoring Safeguards.** *Select one:*

☐	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
☒	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i> Services and supports to clients are monitored directly by case managers on a monthly basis or as needed. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients. Ongoing reviews performed by the AMA LTC Waiver Quality Assurance Unit may include case management personnel files, client files, and visits to participants in their homes. A retrospective review will also be conducted by the AMA LTC Waiver Quality Assurance Unit.

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Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

☐	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
☒	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

☐	Yes. The State requests that this waiver be considered for Independence Plus designation.
☒	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

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- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

☐	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
☐	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
☐	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

☐	Waiver is designed to support only individuals who want to direct their services.
☐	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
☐	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

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f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

☐	The State does not provide for the direction of waiver services by a representative.
☐	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
☐	Waiver services may be directed by a legal representative of the participant.
☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☐	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
☐	Governmental entities
☐	Private entities
☐	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

☐	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
☐	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: _____
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: _____
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i> <i>Supports furnished when the participant is the employer of direct support workers:</i> ☐ Assist participant in verifying support worker citizenship status ☐ Collect and process timesheets of support workers ☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

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	☐	Other (<i>specify</i>):
	<i>Supports furnished when the participant exercises budget authority:</i>	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance-of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>	
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other (<i>specify</i>):
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

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- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

☐	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
☐	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

- k. Independent Advocacy** (*select one*).

☐	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
☐	No. Arrangements have not been made for independent advocacy.

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

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- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. Check each that applies:

☐	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:</i>
☐	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)

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☐	Other (<i>specify</i>):

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b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other <i>(specify)</i> :

- ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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- iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

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iv. Participant Exercise of Budget Flexibility. *Select one:*

☐	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
☐	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a. Description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.

As part of assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

b. Following is a description of the State's procedures for allowing individuals to choose either institutional or home and community-based services

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the form and has no legal or responsible party who can sign. In such a situation, services will not be denied just because a written choice statement cannot be obtained. The case manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

c. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42

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C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the case manager discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/ representative.

Whenever there is a decision by the administering agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Operating Agencies will issue a written 10 day advance notice to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. A copy of the notice will be forwarded to the Medicaid Agency,

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Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

☒	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
☐	No. This Appendix does not apply (<i>do not complete Item b</i>)

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency does operate another dispute resolution process, the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a fair hearing. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the case manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing.

At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within sixty days of the date of the informal conference decision. The document referring to the participant's appeal rights is maintained in the waiver participant's home for future reference.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. A written request for a hearing must be filed within sixty (60) days following the action with which he/she is dissatisfied. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. 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/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 plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper,

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Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of Federal or State law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☒	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver <i>(complete the remaining items)</i> .
☐	No. This Appendix does not apply <i>(do not complete the remaining items)</i>

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The following State Agencies are responsible for the operation of the grievance/complaint system:

1. Alabama Department of Public Health(ADPH)
2. Alabama Department of Senior Services(ADSS)
3. Alabama Medicaid Agency(AMA)

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ADPH and ADSS are responsible for explaining the procedures to clients of filing complaints and grievances. ADPH and ADSS must also have procedures in place that will assure AMA that 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 ADPH, ADSS, or the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions in the AMA LTC Waiver Quality Assurance Unit. 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 ADPH or ADSS within two (2) working days. If they are received by ADPH or ADSS a copy will be forwarded to AMA LTC Program Management Unit within two (2) working days if the client's health and safety are at risk. Otherwise, the complaint/grievance should be entered on the quarterly log that is submitted to AMA.

c. ADPH or ADSS 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 OA to the AMA LTC

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Waiver Quality Assurance 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 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. ADPH or ADSS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risk exist.

f. Final determinations including any adverse findings will be reported to the AMA, LTC Program Management Unit.

g. The AMA will contact the client via telephone or targeted survey to ensure full resolution to the incident has been completed in a satisfactory manner.

h. On a quarterly basis, ADPH and ADSS will forward all grievance logs to AMA LTC Waiver Quality Assurance Unit for review, tracking, and assurance that resolutions have been completed.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Requirements

<u>Incident Types</u>	<u>Timeframes</u>
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

Definitions

Physical Abuse—the infliction of physical pain, injury or the willful deprivation by a care giver or other person of necessary services to maintain physical and mental health.

Sexual Abuse—any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include rape, incest, sodomy, and indecent exposure.

Verbal Abuse—the infliction of disparaging and angry outbursts such as name calling, blaming, or accusatory comments.

Neglect— the failure of a caregiver to provide food, shelter, clothing, medical services, or healthcare for the person unable to care for himself or herself; or the failure of the person to provide these basic needs for himself or herself when the failure is the result of the person's mental or physical inability.

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Mistreatment-Actions that cause harm or create serious risk of harm whether intended or not, to a vulnerable person, by the caregiver or another person, or failure of a caregiver to satisfy the basic need or to protect the child or adult from harm.

Death-the permanent suspension of consciousness and the end of life.

Exploitation-the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Moderate Injury-any observable and substantial impairment of a person's physical health such as temporary loss or impairment.

Major Injury-any observable and substantial impairment that results in permanent or temporary impairment, such as fractures, injury to internal organs, burns, or physical disfigurement of the body. These injuries may result in hospitalization.

Natural Disaster-the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.

Fire- a situation in which something such as a building or an area of land is destroyed or damaged by burning.

Fall- an incident that causes a person to drop suddenly from an up-right position which may result in harm.

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human resources, law enforcement authorities, physicians, caregiver's individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976

All physicians, osteopaths, chiropractors and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

Other incidents such as falls must be reported within 24 hours to the Provider Agency, the Alabama Medicaid Agency, the Alabama Department of Public Health and the Alabama Department of

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Senior Services in a timely manner based upon the circumstances surrounding the incident.

Child Abuse Prevention and Treatment Act 1974

Alabama law is clear on reporting abuse and neglect of children under the age of 18. For example, physicians, teachers, social workers, nurses, day care workers or anyone who comes in contact with suspected child abuse or neglect should make a report to those who can take action. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that a child has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the State Child Abuse Reporting Hotline (334- 242-9500).

- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with consumers to encourage them to talk about what is important to them as well as what they do not like. Each recipient is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the recipient's rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand. The case manager and the DSP is responsible for informing the client/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect/ or exploitation.

- c. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Alabama Department of Public health and the Alabama Department of Senior Services are the entities that receive reports of critical events or incidents. Each operating agency (OA) will investigate the critical events reported and make a decision within seven (7) working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse require an investigation. If the OA determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and arrange when appropriate. Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

- d. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Alabama Department of Public Health and the Alabama Department of Senior Services are responsible for overseeing the reporting of and response to critical incidents or events that affect

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waiver participants through individual/family interviews. The operating agency will notify Medicaid's E & D Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken. In addition, Medicaid's LTC Waiver Quality Assurance Unit is responsible for overseeing the reporting of and response to critical incidents through a review of quarterly participation satisfaction surveys, a review of complaint logs, medical record reviews, DSP personnel record reviews, and onsite home and provider visits, when deemed necessary.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion (*select one*):

☒	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency: The Alabama Department of Public Health (ADPH): Monthly monitoring of participants health and welfare and provider quality reviews. The Alabama Department of Senior Services (ADSS): Monthly monitoring of participants health and welfare and provider quality reviews. The Department of Human Resources (ADHR): certain incidents of abuse, neglect and exploitation must be reported to ADHR by law. The Alabama Medicaid Agency: Annual review of ADPH and ADSS investigations.
☐	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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b. Use of Restrictive Interventions

☒	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency: The Alabama Department of Public Health and the Alabama Department of Senior Services are responsible for detecting the unauthorized use of restrictive interventions through monthly face to face visits as well as supervisory visits every 60 days.
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The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

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- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

☐	Yes. This Appendix applies <i>(complete the remaining items)</i> .
☒	No. This Appendix is not applicable <i>(do not complete the remaining items)</i> .

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

☐	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. <i>(complete the remaining items)</i>
☒	Not applicable <i>(do not complete the remaining items)</i>

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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iii. Medication Error Reporting. *Select one of the following:*

☐	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
☐	Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

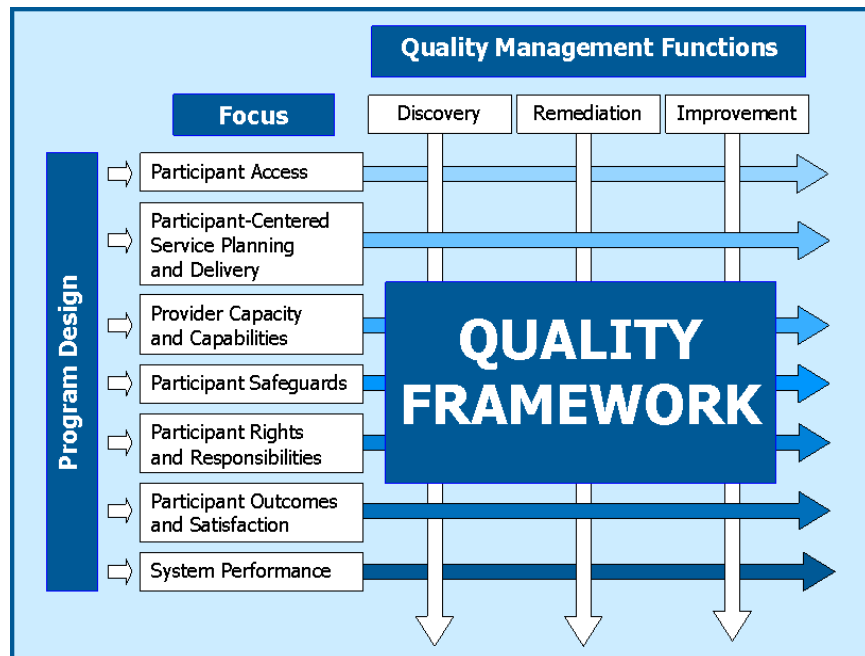
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

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Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Description of the Quality Management Program for the Elderly and Disabled Waiver

The Quality Management Strategy for the Elderly and Disabled (E & D) Waiver is:

AMA LTC Waiver Quality Assurance Unit is responsible for collecting data quarterly and annually regarding the quality of services provided from various sources for the E & D Waiver program. The Quality Framework is used as a guide to assess seven (7) Program Design Focus areas from samples of waiver participants, case management and direct service providers' records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, consumer satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine clients' satisfaction with resolutions.

Data is collected through an annual review of each operating agency which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all applicants approved by the AMA is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of case managers and other employees' personnel records are reviewed to ensure basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months until they are found to be in compliance.

The collected data is reported quarterly and annually to each Operating Agency. AMA LTC Waiver Quality Assurance Unit in collaboration with the LTC Division, will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access:

Sources of data

- Case Management Records
- Home Visits
- DSS Queries
- Consumer Surveys

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Participant –Centered Service Planning and Delivery:

Sources of data

Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities:

Sources of data

Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards:

Sources of data

Case Management Records
Consumer Surveys
Home Visits
Site Visits

Participants Rights and Responsibilities:

Sources of data

Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction:

Sources of data

Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance:

Sources of data

Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborated Meeting with Operating Agency to enhance the administration of the Program
Subcontractor Client Records

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The following indicators are reported to the operating agencies and Medicaid's Long Term Care Division:

- Percentage of client/family reporting satisfaction with waiver services and needs met.
- Percentages of client/family reporting they feel safe and secure in the home and community.
- Percentage of client/family reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of client/family reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the client's needs and preferences.
- Evidence that each operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that each operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

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Appendix I: Financial Accountability
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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medicaid's post-payment financial audit program for the E & D Waiver is designed to ascertain that only reasonable and allowable expenses are included in the cost reports received from the operating agencies. Cost reports are due to Medicaid no later than 90 days after the fiscal year end. An audit of the cost reports is conducted annually. These audits are limited in scope. The basis for the audit is a comparison of Medicaid's adjudicated claims file to the provider's cost report. The auditor will conduct a sampling process of the provider's expenditures. The sample includes, but is not limited to; provider contracts, cost allocation, previous audits, cash disbursements, general ledger accounts, cash receipts, verification of deposits, payroll records including employee time sheets and cancelled checks, vendor invoices, and all vouchers or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditor's findings and opinion regarding compliance and internal control. After the sample is completed, the auditor will make adjustments to the cost report if necessary. The provider's adjusted cost report is compared to Medicaid's paid claims file for final settlement.

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APPENDIX I-2: Rates, Billing and Claims

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates for E & D Waiver services are established by Medicaid. They are prospective rates that are based on audited historical costs with consideration given to the health care index and renegotiated contracts. Medicaid pays private and public contractors the same rate. An OA may request an interim increase or decrease at any time. If approved by Medicaid, the adjusted rate allows claims to be paid at a rate that is closer to the provider's actual cost. If a rate adjustment is retroactive, previously paid claims are recouped and repaid at the adjusted rate. At fiscal year end, the total amount paid by the OA is divided by the total number of units served, and an average rate per service is determined. Medicaid uses the average rate to determine the final settlement.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

As each waiver year is audited, this cost like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost. Cost Reports from the OAs are due to Medicaid by December 31. Cost settlements are made no later than September 30 of the following year.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Each waiver participant, once approved, is added to the Alabama Medicaid's Long Term Care File. This file holds approved dates of eligibility for waiver services.

Providers billings flow directly from the providers to the Medicaid MMIS through Electronic Data System (EDS), the Fiscal Intermediary as follows:

- Payments made by Medicaid to providers are on a cost reimbursement basis. Each covered service is identified on a claim by a HCPC code.
- For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. Each service type is identified by Procedure Code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.
- If the submitted claims covers dates of service where part, or all of which were covered in

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a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.

- Payment is based on the number of units of service reported on the claim for each procedure code.
- Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.
- All claims must be filed within twelve months from the date of service. Medicaid recovers payments that exceed actual allowable cost.
- Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement.

c. Certifying Public Expenditures (select one):

☐		Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
☐		Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
☐		Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
☒		No. Public agencies do not certify expenditures for waiver services.

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- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the HCPC code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State –determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

☒	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
☐	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
☐	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
☐	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☒	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal

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financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☒	No. The State does not make supplemental or enhanced payments for waiver services.
☐	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

- d. Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

☒	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i> The Alabama Department of Public Health and Alabama Department of Senior Services are the operating agencies for the E/D Waiver. These state agencies provide EDW services such as: case management, personal care, homemaker, etc.
☐	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- e. Amount of Payment to Public Providers.** *Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

☒	The amount paid to public providers is the same as the amount paid to private providers of the same service.
☐	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
☐	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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- f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☐	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
☒	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
	Medicaid bills ADPH and ADSS the non-federal share plus a 1% administrative fee. The Alabama Medicaid Agency does not return any portion of the 1% administrative fee to CMS.
☐	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

- g. Additional Payment Arrangements**

- i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

☒	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	ADPH and ADSS
☐	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

- ii. Organized Health Care Delivery System.** *Select one:*

☒	Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	The ADPH, ADSS, and the thirteen Area Agencies and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish. Free choice of providers is assured by the policies and procedures in effect and practices carried out are case managers. All providers are certified and monitored by Quality Assurance reviews performed by ADPH, ADSS or Medicaid. All subcontractors are submitted to the state

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	for review of applicable provisions.
☐	No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

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iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

☐	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
☐	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
☒	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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APPENDIX I-4: Non-Federal Matching Funds

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	Appropriation of State Tax Revenues to the State Medicaid agency
☒	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c: The source of non-federal funds for the HCBS Waiver for the Elderly and Disabled Waiver is the general fund appropriations to ADPH and ADSS. These funds are 106, general fund; 349, other funds such as federal, intergovernmental transfers, drug rebates, and other small amounts; 564, Health Care Trust Funds for provider taxes; and 1047, tobacco revenue. These funds are for the sole use of Medicaid once the appropriation is made by the Legislature. The Alabama Legislature does not line item budget any revenue or expenditure for Medicaid. In other words, no revenue comes to Medicaid earmarked for certain expenditures. It is up to Medicaid how a voucher is coded and thus charged. If Medicaid has any balance in fund 106 at the end of the year, it does not revert back to the State general fund.
☐	Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

- b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	Appropriation of Local Revenues. Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

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X	Not Applicable. There are no non-State level sources of funds for the non-federal share.

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- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

X	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
○	The following source (s) are used. <i>Check each that applies.</i>
☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
For each source of funds indicated above, describe the source of the funds in detail:	
None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.	

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

☒	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
☐	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

☐	Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i>
☒	No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☒	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
☐	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. **Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge <i>(specify)</i> :

- ii **Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

--

- iii. **Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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- iv. Cumulative Maximum Charges.** Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

☐	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
☐	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

- v. Assurance.** The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

- b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
☐	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):			NH				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	9,659	11,627	21,286	31,413	2,510	33,923	12,637
2	10,009	12,046	22,055	32,544	2,601	35,145	13,090
3	10,368	12,480	22,848	33,716	2,694	36,410	13,562
4	10,742	12,929	23,671	34,930	2,791	37,721	14,050
5	11,130	13,394	24,524	36,186	2,892	39,078	14,554

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	
Year 1	9205	9205	
Year 2	9205	9205	
Year 3	9205	9205	
Year 4 (renewal only)	9205	9205	
Year 5 (renewal only)	9205	9205	

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Average length of stay is derived by dividing the total number of days in a waiver year by the total number of clients served. This information is based on data in the CMS-372 Report for year 10/01/2005-09/30/2006.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

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- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

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☒	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
☐	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1(10/01/2007-09/30/2008)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	15 min	9205	144	\$15.28	\$20,253,945.60
Personal Care	15 min	5339	664	\$4.41	\$15,642,736.10
Homemaker	15 min	6996	896	\$4.49	\$28,113,845.76
Respite Care (Skilled)	15 min	368	1152	\$5.67	\$2,402,657.28
Respite Care (Unskilled)	15 min	1933	1052	\$4.24	\$8,622,107.84
Adult Day Health	Day	368	127	\$18.25	\$852,932.00
Companion	15 min	4603	480	\$3.97	\$8,765,953.20
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	\$26.58	\$1,272,969.36
Frozen Meals**	14 meals per week	921	104	\$26.58	\$2,545,938.72
Breakfast Meals	7 meals per week	644	52	\$12.03	\$402,860.64
Shelf Stable Meals	2 annually	2485	2	\$7.29	\$36,231.30
GRAND TOTAL:					\$88,912,177.80
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					\$9,659.12
AVERAGE LENGTH OF STAY ON THE WAIVER					277

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Waiver Year: Year 2(10/01/2008-09/30/2009)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	15 min	9205	144	\$15.83	\$20,982,981.60
Personal Care	15 min	5339	664	\$4.57	\$16,201,088.72
Homemaker	15 min	6996	896	\$4.65	\$29,132,463.36
Respite Care (Skilled)	15 min	368	1152	\$5.87	\$2,489,564.16
Respite Care (Unskilled)	15 min	1933	1052	\$4.40	\$8,947,470.40
Adult Day Health	Day	368	127	\$18.91	\$883,777.76
Companion	15 min	4603	480	\$4.11	\$9,080,798.40
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	\$27.54	\$1,318,945.68
Frozen Meals**	14 meals per week	921	104	\$27.54	\$2,637,891.36
Breakfast Meals	7 meals per week	644	52	\$12.46	\$417,260.48
Shelf Stable Meals	2 annually	2385	2	\$7.56	\$37,573.20
GRAND TOTAL:					\$92,129,815.12
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					\$10,008.67
AVERAGE LENGTH OF STAY ON THE WAIVER					277

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Waiver Year: Year 3(10/01/2009-09/30/2010)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	15 min	9205	144	\$16.40	\$21,738,528.00
Personal Care	15 min	5339	664	\$4.74	\$16,794,892.30
Homemaker	15 min	6996	896	\$4.82	\$30,182,423.04
Respite Care (Skilled)	15 min	368	1152	\$6.09	\$2,579,650.56
Respite Care (Unskilled)	15 min	1933	1052	\$4.55	\$9,252,497.80
Adult Day Health	Day	368	127	\$19.59	\$915,558.24
Companion	15 min	4603	480	\$4.26	\$9,406,690.80
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	\$28.53	\$1,366,358.76
Frozen Meals**	14 meals per week	921	104	\$28.53	\$2,732,717.52
Breakfast Meals	7 meals per week	644	52	\$12.91	\$432,330.08
Shelf Stable Meals	2 annually	2485	2	\$7.83	\$38,915.10
GRAND TOTAL:					\$95,440,562.20
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					\$10,368.34
AVERAGE LENGTH OF STAY ON THE WAIVER					277

State:	Alabama
Effective Date	October 1, 2008

Waiver Year: Year 4 (renewal only) (10/01/2010-09/30/2011)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	15 min	9205	144	\$16.99	\$22,520,584.80
Personal Care	15 min	5339	664	\$4.91	\$17,397,558.62
Homemaker	15 min	6996	896	\$4.99	\$31,263,724.80
Respite Care (Skilled)	15 min	368	1152	\$6.31	\$2,672,916.48
Respite Care (Unskilled)	15 min	1933	1052	\$4.72	\$9,598,195.52
Adult Day Health	Day	368	127	\$20.30	\$948,740.80
Companion	15 min	4603	480	\$4.41	\$9,743,630.40
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	\$29.56	\$1,415,687.52
Frozen Meals**	14 meals per week	921	104	\$29.56	\$2,831,375.04
Breakfast Meals	7 meals per week	644	52	\$13.37	\$447,734.56
Shelf Stable Meals	2 annually	2485	2	\$8.11	\$40,306.70
GRAND TOTAL:					\$98,880,455.24
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					\$10,742.04
AVERAGE LENGTH OF STAY ON THE WAIVER					277

State:	Alabama
Effective Date	October 1, 2008

Waiver Year: Year 5 (renewal only) (10/01/2011-09/30/2012)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	15 min	9205	144	\$17.60	\$23,332,465.80
Personal Care	15 min	5339	664	\$5.09	\$18,026,813.16
Homemaker	15 min	6612	896	\$5.17	\$32,392,039.68
Respite Care (Skilled)	15 min	368	1152	\$6.53	\$2,769,361.92
Respite Care (Unskilled)	15 min	1933	1052	\$4.89	\$9,943,893.24
Adult Day Health	Day	368	127	\$21.03	\$982,895.47
Companion	15 min	4603	480	\$4.57	\$10,097,140.80
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	\$30.62	\$1,466,453.04
Frozen Meals **	14 meals per week	921	104	\$30.62	\$2,932,906.08
Breakfast Meals	7 meals per week	644	52	\$13.86	\$464,143.68
Shelf Stable Meals	2 annually	2485	2	\$8.40	\$41,748.00
GRAND TOTAL:					\$102,449,860.87
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					\$11,129.81
AVERAGE LENGTH OF STAY ON THE WAIVER					277

State:	Alabama
Effective Date	October 1, 2008

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State:	Alabama
Effective Date	October 1, 2008

Waiver Year: Year 3						
Waiver Service	Col. 1 Check if included in capitation	Col. 2 Unit	Col. 3 # Users	Col. 4 Avg. Units Per User	Col. 5 Avg. Cost/ Unit	Col. 6 Total Cost
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	Alabama
Effective Date	October 1, 2008

[illegible]

State:	Alabama
Effective Date	October 1, 2008

[illegible]

State:	Alabama
Effective Date	October 1, 2008