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States must ensure certain information is submitted to CMS no later than January 1, 2023 to document state and provider compliance with HCBS regulatory criteria. The following summarizes Alabama’s methodologies for each of the required elements:

1. Description of how the state’s oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations.

**Nursing Facility (NF) Level of Care Waivers:** There are four NF level of care waivers: Elderly and Disabled (E&D), Alabama Community Transition (ACT), Technology Assisted (TA) and State of Alabama Independent Living (SAIL). The State made the following modifications, pursuant to review and approval by the Alabama Medicaid Agency (AMA):

- AMA proposed language changes to administrative rules to incorporate HCBS requirements, all of which will be final by March 17, 2023.
- The Operating Agencies for the NF level of care waiver programs respectively modified the Alabama Department of Senior Services (ADSS) Policy and Procedure Manual and the Alabama Department of Rehabilitation Services (ADRS) SAIL Policy and Procedure Manual to incorporate HCBS requirements.
- There are no provider owned or operated residential settings for these four NF level of care waivers. Rather, services are delivered in the private dwellings of the waiver participants. Each participant’s choice of dwelling, chosen by the individual through a person-centered planning process, is verified through a site visit prior to enrollment by an assigned Case Manager. Changes in residence are to be reported monthly by waiver case managers and must be verified by a site visit. The State also modified the Case Management Monthly Home Visit Tools to ensure that monthly case management visits to beneficiaries’ homes included HCBS probes and reporting requirements to initiate remediation for any noted noncompliance.
- For the two NF level of care waivers (E&D and ACT) that include Adult Day Health (ADH) as an available service, ADSS and AMA significantly modified the audit tool and processes to assess HCBS compliance on an annual basis. The audit tool questions and protocols are designed to evaluate policies and procedures, as well as the actual experience of the individuals attending the program. As such, it allows the State to assess the current level of compliance, identify areas of noncompliance that require remediation and offer opportunities for systemic and focused technical assistance. HCBS requirements are designated as mandatory, and any noncompliance with mandatory elements require a Corrective Action Plan (CAP).

- In addition to person-centered planning training completed by each Operating Agency, all case managers must complete an AMA-sponsored training on Person-Centered Thinking.

**Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) Level of Care Waivers:** There are two ICF/IID level of care waivers, Intellectual Disabilities (ID) and Living at Home (LAH), that are subject to transition planning. A third waiver, the Community Waiver Program (CWP), is a new program implemented in 2021. It was designed to offer supports and services in integrated community settings in a manner that was fully compliant with HCBS requirements from the outset. The State made the following modifications for the ID and LAH waiver programs, pursuant to review and approval by AMA:

- The Alabama Department of Mental Health (ADMH) completed language changes to administrative rules to incorporate HCBS requirements.
- ADMH modified existing ID and LAH policy and procedure manuals to incorporate HCBS requirements.
- ADMH modified both certification and semiannual monitoring tools to incorporate HCBS requirements.
- ADMH significantly modified the person-centered planning process, including, but not limited to, deconflicting case management from provider organizations.

This information is discussed in more detail within Alabama’s Statewide Transition Plan (STP) documents: [Alabama Statewide Transition Plan](#)

2. Description of how the State assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.

**NF Level of Care Waivers:**

For both initial and ongoing HCBS compliance, ADH providers are assessed using the modified audit tool described above.

- For initial audits, prospective ADH providers must be found in compliance with all State and Federal waiver regulations before they provide direct services to clients. For this purpose, ADSS delegates the local Area Agency on Aging (AAA) to conduct an Initial Facility Audit. The purpose of this portion of the on-site audit is to inspect/audit the Facility and ADH Provider Program to determine if waiver requirements and standards, including HCBS requirements, are in place to continue with the contracting process. The AAA will notify ADSS of the review findings in the audit report. Once the new ADH provider is approved to begin serving Medicaid waiver clients, and within 60-90 days after the new program’s first admission of a Medicaid Waiver participant, the AAA must complete a follow-up on-site review to ensure that the actual experiences of Medicaid Waiver participants in the ADH program are fully consistent with the HCBS Final Settings Rule requirements. Compliance with these requirements is mandatory for continued approval of provider status.

- For annual audits, the ADH provider must continue to be in compliance with all HCBS requirements, all of which are deemed mandatory. If any HCBS requirement is found to be noncompliant, an immediate CAP is required. No ADH provider may continue to provide waiver services if remediation is not fully completed and verified within the prescribed CAP timeframe, which cannot exceed 90 days.

**ICF/IID Level of Care Waivers:** For both initial and ongoing HCBS compliance, ID and LAH providers are assessed using both the modified certification and semiannual monitoring tools.

- Regional Certification staff are responsible for ensuring initial HCBS compliance as well as providing an additional layer of ongoing compliance monitoring. Prospective provider agencies are certified initially and must be found in compliance with all State and Federal waiver regulations, including HCBS requirements, before they provide direct services to clients. This process includes policy and procedure reviews and onsite visits. Once the provider is approved to begin serving Medicaid waiver clients, within 60-90 days after the new program's first admission of a Medicaid Waiver participant, certification staff must complete a follow-up on-site review to ensure that the actual experiences of Medicaid Waiver participants in the program are fully consistent with the HCBS Final Settings Rule requirements. Compliance with these requirements is mandatory for continued approval of provider status.
- Existing providers are certified either annually or biennially, or placed on provisional status, depending on their survey score. Settings must meet 100% of all Final Rule criteria during certification. Settings that fail to meet this standard will be placed on provisional certification status for up to 60 days, and a Plan of Action (POA) to address the rules cited must be submitted within 30 days. Failure to submit the POA within the time specified may result in immediate decertification.
  - Prior to the expiration of provisional certification status, the setting will undergo a follow-up site certification review to determine future certification status. During the provisional process, the Regional Office and Advocacy Section of ADMH will provide increased monitoring and technical assistance. If the provider does not achieve 100% compliance with all the Final Rule requirements, the decertification process will be initiated.
  - These annual or bi-annual provider certification visits provide an additional validation of Regional Office Monitoring findings of HCBS compliance, as described below, which occur semi-annually and are the primary means for monitoring settings for HCBS compliance.
- Regional Office Monitors are responsible for continuing to ensure ongoing provider compliance with the Final Rule and will continue to incorporate HCBS settings compliance in their regularly scheduled biannual monitoring of settings. The monitoring tool, which is used for both residential and day habilitation programs, has a dedicated section for the monitor to review HCBS compliance. A CAP will be required as a result of any HCBS non-compliance discovered during routine monitoring and shared with Certification staff. Should the provider not remediate, the provider will be placed in a provisional status, as described above. The HCBS

decertification process will be instituted if ADMH-DDD determines no remediation is possible.

This information is discussed in more detail within Alabama's Statewide Transition Plan (STP) documents: [Alabama Statewide Transition Plan](#)

3. Description of a beneficiary's recourse to notify the State of provider non-compliance (grievance process, notification of case manager, etc.) and how the State will address beneficiary feedback.

For all waivers, the State has in place a complaint and grievance process that is used by a beneficiary to notify the State of provider non-compliance. As a part of the informed choice notification that takes place at enrollment and at least annually, the waiver case manager provides each beneficiary with a written and verbal description of the complaint and grievance procedures. Prior to March 17<sup>th</sup>, 2023, each Operating Agency had its own informed choice documentation describing beneficiaries' rights and responsibilities, including rights delineated under the HCBS Final Settings Rule, and how/where to file a grievance and/or complaint.

As of March 17<sup>th</sup>, 2023, each Operating Agency incorporated into the informed choice process a standardized AMA-designed HCBS Notification to ensure that beneficiaries have access to a full description of the HCBS requirements, as well as their recourse options if they feel a provider is noncompliant. The waiver case manager provides the HCBS Notification in writing, and uses it as a guide to discuss the HCBS requirements and expectations with the beneficiary and/or their representative, including the participant's right to experience a fully HCBS compliant setting and the course of action to take if the participant and/or their representative feel that the setting is noncompliant. This includes notifying the case manager, notifying the designated representatives at the respective waiver's Operating Agency, and, if necessary, initiating the complaint and/or grievance process.

While a beneficiary has the option to contact a representative of the Operating Agency directly with a complaint or grievance, these processes typically begin with a notification to the case manager, who will seek to obtain a satisfactory resolution. If this is not possible, the complaint will be investigated by the respective waiver's Operating Agency. All Operating Agencies are required to document and track all complaints and grievances through to resolution. In addition, Operating Agencies are required to review complaints and grievances to ensure that no health and safety risks exist, determine if there are any patterns, including HCBS noncompliance, that require remediation, and take any necessary corrective actions.

Final determinations regarding complaints and grievances, including any adverse findings, are reported to AMA. All Operating Agencies are also required to submit to AMA a log of all complaints/grievances quarterly for review, tracking, and assurance that resolutions have been completed. Quarterly, AMA reviews all complaint and grievance data from the

Operating Agencies to identify any potential trends or issues, including HCBS noncompliance, and to determine/take needed systemic remediation.