

ALABAMA MEDICAID AGENCY

NOTICE OF INTENDED ACTION

RULE NO. & TITLE: Covered Services 560-X-44-.04

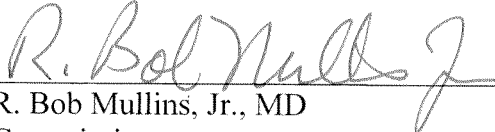
INTENDED ACTION: Amend 560-X-44-.04(14)

SUBSTANCE OF PROPOSED ACTION: The above-referenced chapter is being amended to delete "bill paying" from the homemaker service.

TIME, PLACE, MANNER OF PRESENTING VIEWS: Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624, 334-242-5833. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than June 5, 2012.

CONTACT PERSON AT AGENCY: Stephanie Lindsay , Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624.


R. Bob Mullins, Jr., MD
Commissioner

Rule No. 560-X-44-.04. Covered Services

(1) Community Case Management Services

(a) Community Case Management is a comprehensive system of providing services which will assist waiver recipients in gaining needed 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. Community Case Management services may be used to locate, coordinate, and monitor necessary and appropriate services. Community Case Management activities will also be used to assist in the transition of an individual from an institutional setting to the community. Community Case Management activities to facilitate transition are limited to a maximum of 180 days prior to discharge into the community.

(b) Case managers are responsible for Plan of Care development and ongoing monitoring of the provision of waiver services and non-waiver services included in the recipient's Plan of Care.

(c) Case management will be provided by a case manager employed by or under contract with the ADRS.

(2) Personal Care Services

(a) Personal care services are services that provide assistance with eating, bathing, dressing, personal hygiene and activities of daily living. Services may include assistance with preparation of meals but do not include the cost of meals themselves. When specified in the Plan of Care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

(b) Personal care services will be provided by individuals employed by a certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency and supervised by a case manager. Persons providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal care services may be provided by family members or friends only if a lack of other qualified providers in applicable remote areas exists.

(d) Services provided to each client are dependent on individual need as set forth in the client's Plan of Care.

(3) Home Modifications (Environmental Accessibility Adaptations - EAA)

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

(b) Adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as floor covering, roof repair, central air conditioning, etc.

Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home or permanent adaptations to rental property are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

(c) Environmental accessibility adaptations will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building codes.

(d) Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee for prior authorization and must be listed on the client's Plan of Care. Any expenditure in excess of the maximum allowed amount must be approved by the State Coordinator and the Medicaid designated personnel.

(e) The service also may be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(f) Limits on Home Modifications (EAA) are \$5,000 per waiver participant for the entire stay on the waiver.

(4) Personal Emergency Response System

(a) Personal Emergency Response System (PERS) is an electronic service which enables certain high-risk patients to secure help in the event of an emergency. The client may also wear a portable "help" button which allows the client flexibility in mobility. The system is connected to a patient's phone and programmed to signal a response center once a patient's "help" button is activated.

(b) PERS must be provided by trained professionals. The PERS staff must complete a two-week training period for familiarization with the monitoring system and proper protocol to provide appropriate response action.

(c) Initial setup and installation of PERS must be on the individual's Plan of Care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

(d) The service also may be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(5) Medical Supplies

(a) Medical supplies include: devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency and the ADRS.

(c) Medical supplies service shall not exceed \$1,800.00 annually per recipient.

(6) Assistive Technology

(a) Assistive technology includes devices, pieces of equipment or products that are modified or customized which are used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include evaluation of need, acquisition, selection, design, fitting, customizing, adaptation, application, etc. This service must be listed on the individual's Plan of Care. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

(b) The service must be medically necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the ACT Waiver. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate. All items shall meet applicable standards of manufacture, design and installation.

(c) Assistive technology and transitional assistive technology services must be prior authorized and approved by the Alabama Medicaid Agency, or its designee and must be listed on the client's Plan of Care.

(d) Assistive technology services will be provided by licensed individuals or businesses capable of supplying the needed equipment and/or supplies. Assistive technology must be approved by the Alabama Medicaid Agency and must be listed in the individual's Plan of Care.

(e) Providers of this service will be those who meet provider qualifications and who have a signed provider agreement with the ADRS. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

(f) Assistive Technology has a cumulative limit of \$15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(g) The service may also be provided to assist the individual transitioning from an institution to the ACT Waiver, but should not be billed until the first day the client is active on the waiver.

(7) Assistive Technology Repairs

(a) Assistive technology repairs will provide for the repair of devices, equipment, or products that were previously purchased by the Alabama Medicaid Agency for the recipient. Repairs include replacement of parts or batteries to allow the equipment to operate.

(b) The provider should be responsible for replacement or repair of the equipment or any part thereof that is found to be non-functional because of faulty material or workmanship within the guarantee of the manufacturer without any charge to the recipient or the ADRS. Only repairs outside the warranty period will be eligible for reimbursement.

(c) Businesses providing this service will possess a business license and also be required to give a guarantee on work performed.

(d) This service must be listed on the recipient Plan of Care before being provided.

(e) Assistive Technology has a cumulative limit of \$15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(8) Evaluation for Assistive Technology

(a) Evaluation for assistive technology will provide evaluations and determinations of a client's needs for equipment prescribed by a physician to promote health, safety, and prevent institutionalization or to assist an individual to transition from an institution to the ACT Waiver. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

(b) The individual providing evaluation must be a physical therapist licensed to do business in the state of Alabama and enrolled as a provider with the ADRS. The physical therapist should not have any financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of assistive technology equipment/devices.

(c) A written copy of the physical therapist's evaluation must accompany the prior authorization request and a copy must be kept in the recipient's file. This service must be listed on the recipient's Plan of Care before being provided.

(d) Assistive Technology has a cumulative limit of \$15,000 per recipient per lifetime. This includes: purchase, repair, and/or evaluation.

(9) Personal Assistance/Attendant Service

(a) Personal Assistance/Attendant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual if that person did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform everyday activities. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those seeking competitive employment either in their home or in an integrated work setting.

(b) Personal Assistance/Attendant Services will be provided by a personal care attendant under the supervision of a registered nurse who meets the Personal Assistance/Attendant Service staffing requirements. Individuals providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal Assistance/Attendant Services may be provided by family members or friends only if there is a lack of other qualified providers in remote areas.

(10) Adult Day Health Services

(a) Adult Day Health Service provides social and health care in a community facility approved to provide such care. Health education, self-care training, therapeutic activities, and health screening shall be included in the program.

(b) Adult Day Health Service is provided by facilities that meet the minimum standards for Adult Day Health Centers. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health Services meets the prescribed standards.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not listed on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's care plan will be recovered.

(11) Respite Care

(a) Respite care is given to individuals unable to care for themselves on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual. Respite is intended to supplement not replace care provided to waiver clients. Respite is not an entitlement. It is based on the needs of the individual client and the care provided by the primary caregiver.

(b) Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual. All other waiver services except case management will be discontinued during the time in-home respite is being provided.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's care plan will be recovered.

(12) Adult Companion Services

(a) Adult 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 goals may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

(b) Other service definitions include accompanying a client to a medical appointment, grocery shopping or picking up prescription medications. The companion service is available to only those clients living alone. Companion services cannot be provided at the same time as other approved waiver services with the exception of case management services. Companion services must not exceed four hours daily.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) Companion service is not an entitlement. It is based on the needs of the individual client.

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the care plan shall be recovered.

(13) Home Delivered Meals

(a) Home delivered meals are provided to an eligible individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

(b) This service will provide at least one nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability/dependency and who require nutritional assistance to remain in the community, and do not have a caregiver available to prepare a meal for them.

(c) This service will be provided as specified in the Plan of Care and may include seven or 14 frozen meals per week. Clients will be authorized to receive one unit of service per week. One unit of service is a seven-pack of frozen meals. Clients may be authorized to receive two units of service per week. These clients will receive two seven-packs of frozen meals or one seven-pack of frozen meals and one seven-pack of breakfast meals.

(d) In addition to the frozen meals, the service may include the provision of two or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's Plan of Care.

(e) One frozen meal will be provided on days a client attends the Adult Day Health Centers. Meals provided, as part of this service, shall not constitute a "full nutritional regimen (three meals per day)".

(f) All menus must be reviewed and approved by a Registered Dietitian with licensure to practice in the State of Alabama.

(g) The meals must be prepared and/or packaged, handled, transported, served, and delivered according all applicable health, fire, safety, and sanitation regulations.

(h) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's care plan will be recouped.

(i) During times of the year when the State is at an increased risk of disaster from hurricanes, tornadoes, 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.

(14) Homemaker Services.

(a) Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. They are provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the recipient.

(b) A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(15) Skilled Nursing

(a) The Skilled Nursing service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing.

(b) Skilled nursing under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

(16) Transitional Assistance Service

(a) Transitional Assistance service is a service that will assist with the expense of transitioning from a nursing facility to the community.

(b) Examples of expenses may include: deposits for utilities, pest eradication, one-time cleaning prior to occupancy, essential household furnishings, and moving expenses.

(c) Transitional Assistance Service cannot exceed \$1,500.

(d) This service may be provided to the client prior to transition from the institution, the service should not be billed until the first day the client is active on the waiver.

ACT Waiver services provided to assist an individual to transition to the community shall be billed once the client has been successfully transitioned to the community. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate and not the service rate.

Author: Mattie M. Jackson, Program Manager, LTC Program Management Unit.

Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based ACT Waiver.

History: New Rule: Filed February 10, 2012; effective March 16, 2012. Amended: Filed April 20, 2012.