UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JONATHAN PAUL BOYD,	)	
	)	
Plaintiff,	)	Civil Action Number:
	)	
vs.	)	2:10-cv-00688-MEF-TFM
	)	
CAROL A. HERRMANN-STECKEL,	)	
in her official capacity as Commissioner,	)	
Alabama Medicaid Agency,	)	
	)	
Defendant.	)	

STATEMENT OF INTEREST OF THE UNITED STATES OF AMERICA

The United States respectfully submits this Statement of Interest, pursuant to 28 U.S.C. § 517,[1] because this litigation implicates the proper interpretation and application of the integration mandate of title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101, *et. seq*. *See Olmstead v. L.C.*, 527 U.S. 581 (1999). The Attorney General has authority to enforce title II of the ADA, and pursuant to Congressional mandate, to issue regulations setting forth the forms of discrimination prohibited by Title II. 42 U.S.C § 12134. Accordingly, the United States has a strong interest in the resolution of this matter and urges the Court to grant the plaintiff's motion for preliminary injunction.

INTRODUCTION

Plaintiff Jonathan Paul Boyd, a young man with quadriplegia who receives services in the State of Alabama's Medicaid program, is enrolled with a scholarship as a graduate student at the

[1] 28 U.S.C. § 517 states that "[t]he Solicitor General, or any officer of the Department of Justice, may be sent by the Attorney General to any State or district in the United States to attend to the interests of the United States in a suit pending in a court of the United States, or in a court of a State, or to attend to any other interest of the United States."

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University of Montevallo, where he is pursuing a Master's degree in community counseling. Because of the defendant's discriminatory administration of Alabama's Medicaid program, however, Mr. Boyd has been relegated to a nursing home unnecessarily and indefinitely – significantly interfering with his ability to participate in his graduate program, school activities and community life generally. The defendant refuses to make reasonable modifications to the State's Medicaid program to enable Mr. Boyd to live in the community, despite the substantial evidence that Mr. Boyd wants to live in the community, is capable of doing so, and that providing him services in the community instead of a nursing home would actually save the State money. As a result, Mr. Boyd remains needlessly institutionalized in violation of Title II of the ADA, 42 U.S.C. § 12131, *et. seq.* ("ADA"), Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) and the Supreme Court decision *Olmstead* v. *L.C.*, 527 U.S. 581 (1999). Moreover, Mr. Boyd is suffering irreparable harm each day he remains segregated in a nursing home, where he loses valuable time and educational and other opportunities that no court order in the future can adequately remedy. For these reasons and the reasons set forth below, the Court should grant the plaintiff's motion for preliminary injunction.

STATUTORY AND REGULATORY BACKGROUND

Congress enacted the ADA "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). It found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.[2]

One form of discrimination prohibited by the ADA is a violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing title II,[3] and the Supreme Court's decision in *Olmstead*, 527 U.S. at 586. In *Olmstead*, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id*. at 607.

FACTUAL BACKGROUND

In 1995, while a sophomore at Troy State University, Jonathan Paul Boyd was injured in an accident that resulted in paralysis below the collar bone. (Am. Compl. at ¶ 2.) For the following eleven years, he lived at home with his family in Montevallo, Alabama, where his mother served as his primary caregiver, and he received some services under the State of

[2] Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance").

[3] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. §§ 35.130(d), 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A, p. 571 (2009).

Alabama Independent Living ("SAIL") Medicaid waiver program. (Id. at ¶¶ 17-19). He eventually returned to college in Montevallo and graduated in 2007 with a Bachelor of Arts degree.

When his mother could no longer serve as his primary caregiver, Mr. Boyd entered a nursing home in December 2006, and the waiver services he received prior to that time were terminated. (Id. at ¶ 20.) He remains in the nursing home today, and the services he receives there are provided through the State's Medicaid program.

Early this year, Mr. Boyd was accepted to a graduate program at the University of Montevallo, where he seeks to earn a Master's degree so that he can pursue a career in community counseling. (Am. Decl. of Jonathan Paul Boyd 11-12.) Unlike most students at the University of Montevallo, however, Mr. Boyd cannot participate fully in activities, events and opportunities offered by the school because he is confined to a nursing home, thirteen miles away. (Id.) In the nursing home, Mr. Boyd is subject to curfews, restrictions and regimented activities. (Id. ¶¶ 20-22.) He has no privacy, and is surrounded by constant noise. All of the other nursing home residents are individuals with disabilities and most are much older than Mr. Boyd. (Id.) As a result, he is deprived of the simple pleasure of being around people his own age and choosing what to do with his day. He is also deprived of the opportunity to take full advantage of all the University has to offer, such as athletic events, lectures, author readings, theatrical and musical performances and other school functions. (Id. ¶ 15.)

The State of Alabama has opted to take advantage of Medicaid's waiver programs in order to provide home and community-based services to persons with disabilities who would otherwise be cared for in hospitals and other institutions.[4] The "waiver" authority permits the

[4] States can submit requests for approval to the Centers for Medicare and Medicaid Services

Secretary of Health and Human Services to waive certain Medicaid requirements in order for states to offer these services. *See* 42 U.S.C. § 1396m(b)-(h); 42 C.F.R. §430.25(d). Pursuant to this authority, Alabama administers six waiver programs, including the Elderly and Disabled Waiver and the State of Alabama Independent Living ("SAIL") waiver. The purpose of the Elderly and Disabled waiver is to "provide home and community-based services to elderly and disabled individuals in the community who would otherwise require nursing facility care." *See* Application for a § 1915(c) Home and Community-Based Services Waiver, at 4 (attached as Exhibit 6 to Pl.'s Mem. of Law in Support of Mot. for Prelim. Inj., dated Aug. 17, 2010, ECF No. 4-6) (hereinafter (E/D Waiver Application") The SAIL waiver "provides services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60 …., [including] quadriplegia…." Section 1915(c) Waiver Request, November 2008 (hereinafter "SAIL Waiver Application"), attached hereto as Exhibit A.

By providing services to individuals in the Elderly and Disabled waiver instead of a nursing facility, the State saved annually, on average, more than $10,000 per person during the last three years. *See* E/D Waiver Application at Appendix J-1:1.[5] Similarly, in a cost neutrality demonstration set forth in the SAIL Waiver Application, the State represented that it saved on average more than $15,000 per person to serve individuals through the SAIL waiver instead of a nursing facility. *See* SAIL Waiver Application at 92. Even though it would be less costly to provide services to Mr. Boyd in the community, where he is able to and very much wants to live, defendant has refused to make reasonable modifications to its service program to enable him to do so.

("CMS") to alter the terms of a waiver application at any time. *See* 42 C.F.R. § 441.355.

[5] *See also* 42 C.F.R. § 441.303(f)(1) (providing instructions on terminology used in 1915(c) Waiver Applications).

ARGUMENT

The plaintiff satisfies the requirements for a preliminary injunction. To obtain a preliminary injunction, the moving party must show (1) a substantial likelihood of success on the merits, (2) that he will be irreparably harmed in the absence of an injunction, (3) that the balance of the equities favors granting the injunction, and (4) that the public interest would not be harmed by the injunction. *Mesa Air Group, Inc. v. Delta Air Lines, Inc.*, 573 F.3d 1124, 1128 (11th Cir. 2009). The decision whether or not to issue a preliminary injunction lies within the sound discretion of the trial court. *Charles H. Wesley Educ. Foundation, Inc.* v. *Cox*, 408 F.3d 1349, 1354 (11th Cir. 2005). The "primary justification" for the issuance of a preliminary injunction is to preserve the court's ability to render a meaningful decision on the merits. *Canal Authority of the State of Florida v. Callaway*, 489 F.2d 567, 573, 576 (5th Cir. 1974).[6] Here, preliminary injunctive relief is necessary to prevent the irreparable harm of unnecessary institutionalization. *See Long* v. *Benson*, No. 08cv26, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008) (granting preliminary injunction requiring Florida to provide Medicaid-funded community-based services because irreparable injury would result if plaintiff were forced to enter a nursing home), *aff'd*, No. 08-16261, 2010 WL 2500349 (11th Cir. June 22, 2010).

[6] *See also Charles H. Wesley Educ. Foundation, Inc. v. Cox*, 408 F.3d 1349, 1351 (11th Cir. 2005) (affirming preliminary injunction in a voting rights acts case requiring defendants to process voter registration applications); *Gresham* v. *Windrush Partners, Ltd.*, 730 F.2d 1417, 1425 (11th Cir. 1984) (issuing preliminary injunction requiring defendants to display notices and instruct employees and agents of nondiscrimination policies and finding that "when housing discrimination is shown it is reasonable to presume that irreparable injury flows from the discrimination"); *Haddad v. Arnold*, No. 3:10-cv-00414-MMH-TEM (M.D. Fla. July 9, 2010) (hereinafter "*Haddad* Op.") at 39 (attached as Exhibit B) (issuing preliminary injunction requiring defendants to provide community-based services to plaintiff); *Rogers* v. *Windmill Point Vill. Club Assoc., Inc.*, 967 F.2d 525, 528 (11th Cir. 1992); *Community Services, Inc.* v. *Heidelberg*, 439 F. Supp. 2d 380, 400-401 (M.D. Pa. 2006) (entering preliminary injunction ordering defendants to issue permits for plaintiff to utilize property as long term structured residence for individuals with mental illness).

I. Plaintiff is Likely to Prevail on the Merits of His Claims

To establish a violation of Title II of the ADA, a plaintiff must prove that (1) he has a disability; (2) he is a qualified individual; and (3) he was subjected to unlawful discrimination because of his disability. *Morisky v. Broward County*, 80 F.3d 445, 447 (11th Cir. 1996).[7] Defendants do not dispute that Mr. Boyd is an individual with a disability within the meaning of the ADA and the Rehabilitation Act. Nor do they dispute that he is eligible to receive Medicaid-funded services from the State; indeed, the State pays for the services Mr. Boyd currently receives in the nursing home. Instead, defendant contends that the plaintiff's ADA and Rehabilitation Act claims are "trump[ed]" by the Medicaid Act; that an ADA regulation exempts the State from providing personal services; that Mr. Boyd is not able to live in the community; and that the relief he seeks works an "overhaul" of the State's Medicaid program and requires the creation of an "entirely new State-funded program." These arguments have no merit.

A. Defendant's Interpretation of Federal Law is Unfounded

Defendant argues that Mr. Boyd's ADA and Rehabilitation Act claims "force[] the statutes into conflict" with the Medicaid Act and that the Medicaid Act "trumps" these anti-discrimination statutes. Def.'s Resp. at 45. Specifically, defendant argues that a finding under the ADA and Rehabilitation Act that services must be provided to Mr. Boyd in a community-based setting would conflict with the Medicaid Act because waiver programs are optional, can be limited to target populations, and are approved by the U.S. Department of Health and Human Services Center for Medicaid and Medicare Services ("CMS"). *Id*. at 44. Contrary to

[7] Claims under the ADA and the Rehabilitation Act are treated identically unless, unlike here, one of the differences in the two statutes is pertinent to a claim. *Allmond v. Akal Sec., Inc.*, 558 F.3d 1312, 1316 n.3 (11th Cir. 2009); *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003).

defendant's assertion, Mr. Boyd's claim does not raise any question requiring the Court to reconcile the ADA or Rehabilitation Act with the Medicaid Act.

1. ADA Compliance Does Not Conflict With the Medicaid Act

A determination that Mr. Boyd should be provided services in the most integrated setting appropriate to his needs does not require a finding that the State must provide waiver services as a mandatory (as opposed to optional) Medicaid service, or that such services cannot be limited to a particular target population.[8] Rather, once a state has elected to provide services (whether mandatory or optional under the Medicaid Act), the state must administer those services in accordance with the ADA and Rehabilitation Act. A state that chooses to provide optional services cannot defend against the discriminatory administration of those services simply because the state was not initially required to provide them. *Haddad* Op. at 28-29 ("Defendants have provided no authority for the proposition that a state that chooses to provide Medicaid services, even if otherwise optional, would not be required to comply with the ADA in the provision of those services, just as it would have to comply with the ADA for any other 'services, programs, or activities' provided by a public entity."); *see also Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998) (When a state chooses to provide an optional Medicaid service, it must do so in accordance with the requirements of federal law); *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1182 (10th Cir. 2003) (even though a waiver program is optional, a state may not, under Title II of the ADA, amend optional programs in such a way as to violate the integration mandate).

[8] Indeed, given that he is a person with a physical disability, Mr. Boyd is within the target populations served by the Elderly and Disabled Persons waiver and the SAIL waiver.

Equally unavailing is the defendant's suggestion that approval of the State's Medicaid program by CMS exempts it from making modifications to comply with the ADA or Rehabilitation Act. Def.'s Resp. at 44. The Medicaid Act sets conditions for the availability of federal funds, but the obligation of states to ensure that individuals with disabilities are not needlessly institutionalized is independent of the Medicaid statutes. *See Townsend v. Quasim*, 328 F.3d 511, 518 n.1 (9th Cir. 2003). Thus, although a particular aspect of a state's Medicaid program has been approved, the state may have to request a modification from CMS in order to comply with other laws. CMS has explicitly recognized that the ADA may require states to modify their Medicaid programs under certain circumstances. For example, CMS has issued guidance that the mere fact that a state is permitted to "cap" the number of individuals it serves in a particular waiver program under the Medicaid Act does not exempt the state from seeking a modification of its program to comply with the ADA or other laws. *See* CMS, Olmstead Update No. 4, at 4 (Jan. 10, 2001), available at http://www.cms.hhs.gov/smdl /downloads/smd011001a.pdf ("If other laws (e.g., ADA) require the State to serve more people, the State may…request an increase in the number of people permitted under the HCBS Waiver.") (Attached hereto as Exhibit C).

2. ADA Regulation on Personal Services Does Not Exempt Defendant from Providing the Relief Sought

Defendant also asserts that the ADA's Personal Devices and Services Regulation, 28 C.F.R. § 35.135, exempts the State from having to provide "services of a personal nature." Def.'s Resp. at 48-51. Defendant's interpretation of this regulation is incorrect. The Personal Devices and Services Regulation simply makes clear that Title II does not require a State to provide

personal services where such services are *not "customarily provided."*[9] *See* U.S. Dept. of Justice, ADA Title II Technical Assistance Manual § II-3.6200 (emphasis added).[10]

Indeed, courts that have held that § 35.135 imposes any limits on a state's duty to provide reasonable accommodations have only done so, as the Department of Justice interpretation contemplates, where such devices or services are not "customarily provided." *See, e.g.*, *McCauley v. Winegarden*, 60 F.3d 766, 767 (11th Cir. 1995) ("environmental filtering" device in a courtroom); *Kerry M. v. Manhattan School Dist. #114*, 2006 WL 2862118, at *10 (N.D. Ill. 2006) (collapsible wheelchair in school district's bus service); *Blatch ex rel. Clay v. Hernandez*, 360 F. Supp. 2d 595, 630 (S.D.N.Y. 2005) (expert representatives in tenancy termination proceedings); *Rivera v. Delta Air Lines, Inc*., 1997 WL 634500, at *1-2 (E.D. Pa. 1997) (wheelchair to board airplane); *Adelman v. Dunmire*, 1996 WL 107853, at *3 (E.D. Pa. 1996) (wheelchair in courtroom).[11] Thus, where, as here, the services sought by the plaintiff are

[9] For example, a State's Department of Motor Vehicles need not provide wheelchairs to those who wait in line for a driver's license.

[10] The Technical Assistance Manual provides the Department's interpretation of its ADA regulations, and has been relied upon by the Supreme Court. *See Bragdon v. Abbott*, 524 U.S. 624, 646-647 (1998). The appendix to the Title II regulations also explains that the regulation "parallels an analogous provision" in the regulations implementing Title III. 28 C.F.R. Pt. 35, App. A, p. 574 (2009) (referring to 28 C.F.R. § 36.306). The appendix accompanying the Title III regulations, in turn, explains: "Of course, if personal services are customarily provided to the customers or clients of a public accommodation, e.g., in a hospital or senior citizen center, then these personal services should also be provided to persons with disabilities using the public accommodation." 28 C.F.R. Pt. 36; App. B, p. 732 (2009). Because the Department of Justice's interpretation of its own regulation merits substantial deference, *see Auer v. Robbins*, 519 U.S. 452, 461 (1997), this Court should reject contrary interpretations of the personal services regulation. *See also Coeur Alaska Inc. v. Se. Alaska Conservation Council*, __ U.S. __, 129 S.Ct. 2458, 2469 (2009).

[11] Other courts have interpreted the limits imposed by § 35.135 narrowly. For example, in *A.P. ex rel. Peterson v. Anoka-Hennepin Indep. School Dist. No. 11*, 538 F. Supp. 2d 1125, 1152-53 (D. Minn. 2008), the court held that § 35.135 does not bar a diabetic child's parents from requesting that school district staff be trained and authorized to provide glucagon injections to the child. Similarly, in *Purcell v. Pennsylvania Department of Corrections*, 1998 WL 10236, at *9 (E.D. Pa. 1998), the court rejected the state's argument that it was not required under the

customarily provided in the program in which he is receiving services, the limitation expressed by 28 C.F.R. § 35.135 has no bearing.

3. Defendant's Legal Arguments Were Recently Rejected by Courts in the Eleventh Circuit

The same legal arguments asserted by defendant were recently rejected in two separate *Olmstead* cases pending in federal courts in Florida. In *Haddad* , *supra* n. 6, a woman with quadriplegia, who was on a wait list for services in Florida's home and community-based services waiver, filed a motion for preliminary injunction seeking to enjoin the defendants from refusing to offer her services in the waiver. *Id*. at 2. The defendants opposed the motion, arguing *inter alia* that (1) a finding under the ADA that plaintiff must be served in a waiver program would abrogate or amend the Medicaid Act provisions that allow states to cap their programs and to have the option to provide waiver services, and (2) 28 C.F.R. § 35.135 exempted them from providing personal care services to the plaintiff. *Id*. at 26-29. The district court rejected these arguments and granted the plaintiff's motion for preliminary injunction. It found that defendants' attempt to characterize the plaintiff's ADA claim "as an invalidation of the Medicaid Act is without merit," explaining that it "simply addresse[d] the question of whether [the] Defendants, having opted to provide particular services via the mechanism of a Medicaid Waiver Program, may be required, under the ADA, to provide those same services to her if necessary to avoid imminent, unnecessary institutionalization." *Id*. at 29. With respect to the defendants Section 35.135 argument, the district court found it also "misses the mark," reasoning that when a state chooses to provide certain services, it must do so in a nondiscriminatory fashion. *Id*.

ADA to provide a plastic chair for support in shower to accommodate plaintiff's joint disease.

Similarly, in *Long v. Benson*, a man who was relegated to a nursing home after experiencing a stroke that resulted in paralysis on the left side of his body sought a preliminary injunction requiring the State to provide Medicaid coverage for certified nursing assistance in his home. *Long* 2008 WL 4571903. The district court found that the plaintiff satisfied the requirements for entry of a preliminary injunction, including that he was likely to prevail on the merits of his *Olmstead* claim. *Id.* at 2. On appeal to the Eleventh Circuit Court of Appeals, the state defendants argued, as defendant does here, that 28 C.F.R. § 35.135 does not require them to provide personal care services and that the relief ordered under the ADA impermissibly invalidated the provisions of the Medicaid Act that make waiver programs optional and allow them to be limited. *See Benson v. Long*, Amended Initial Brief of the Secretaries of the Florida Agency for Health Care Administration and the Department of Elder Affairs, 2010 WL 2493235, at *10-16 (Jan. 14, 2009). Finding that the district court did not abuse its discretion, the Eleventh Circuit affirmed the preliminary injunction on June 22, 2010. *Long v. Benson*, No. 08-16261, 2010 WL 2500349, at *1 (11th Cir. 2010).

B. Mr. Boyd is a Qualified Individual with a Disability

Under the ADA, a "qualified individual with a disability" is "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices … meets the essential eligibility requirements for receipt of services or the participation in programs or activities provided by the public entity." 42 U.S.C. § 12131(2). The defendant argues that Mr. Boyd is not a "qualified individual" because Alabama does not "currently [have] a Medicaid waiver program which, as designed, meets his needs." Def.'s Resp. at 54. Defendant's argument conflates the question of eligibility with the question of whether the relief sought is a reasonable modification of the program provided by defendant. There is no dispute that Mr. Boyd is qualified to receive long-term medical care and living assistance through Alabama's

Medicaid program. Moreover, given that he lived in the community for eleven years with adequate support services, it is clear that community-based services are appropriate for his needs. *See Townsend*, 328 F.3d at 516 (individual satisfied eligibility requirement where he was qualified to receive long-term care through state's Medicaid program and showed he benefitted from receiving those services in a community-based setting); *Long*, 2008 WL 4571903, at *2 ("[C]ommon sense and experience suggest there is nothing that can be done for [the plaintiff] in the nursing home that cannot also be done in his apartment complex. Indeed, this is true of most if not all services provided in nursing homes for most if not all patients."). Thus, Mr. Boyd has established that he is a qualified individual with a disability.

Defendant appears to argue that Mr. Boyd is not eligible for community-based services because he has not been assessed by a state treatment professional. As many courts have held, however, a plaintiff need not show that a state's treatment professional has concluded that he can be served in the community. *See Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 310 (E.D.N.Y. 2008) (no eligibility determination from the state's professional is required); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 258 (E.D.N.Y. 2009) (same); *Long*, 2008 WL 4571904, *2 (state "cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community. Otherwise, the right would, or at least could, become wholly illusory."); *Frederick L. v. Dep't of Public Welfare*, 157 F. Supp. 2d 509 (E.D. Pa. 2001) ("*Frederick L. I*") ("*Olmstead* does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the services needs of institutionalized individuals with mental disabilities.").[12]

[12] To the extent defendant suggests that Mr. Boyd is ineligible for services in the Elderly and Disabled waiver because he is not "on the referral list of persons who wish to be enrolled in the E&D waiver," Def.'s Resp. at 54, that argument is also without merit. As Mr. Boyd attested, he

C. With Reasonable Modifications to its Program, the State Can Provide the Services Mr. Boyd Needs to Live in the Community

Defendant mischaracterizes the relief Mr. Boyd seeks as a "new waiver program" and one that would require an "overhaul of the system." Def.'s Resp. at 63. The relief Mr. Boyd seeks is nothing of the sort. Defendant's characterizations are flawed for two reasons. First, they fail to account for the fact that the State is already providing Mr. Boyd with the services he is seeking in this litigation. He simply requests that the State provide those services in a community-based setting rather than an institution. *See Townsend*, 328 F.3d at 517 ("If services were determined to constitute distinct programs based solely on the location in which they were provided, *Olmstead* and the integration regulation would be effectively gutted. States could avoid compliance with the ADA simply by characterizing services offered in one isolated location as a program distinct from the provision of the same services in an integrated location."); *Helen L. v. Didario*, 46 F.3d 325, 337-39 (3d Cir. 1995) (state violated ADA by not providing state-funded attendant care services for which plaintiff was eligible in her own home, rather than a nursing home); *Fisher*, 335 F.3d at 1183 (questioning whether defendants had a valid fundamental alteration defense where plaintiffs were simply requesting that a service for which they are eligible be provided in a community-based setting rather than a nursing home).

Second, Mr. Boyd can be served successfully in the community with services that the State already provides to other individuals with disabilities in the State's community-based

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applied for Alabama's community-based waiver program in October 2008. (Boyd Am. Decl. ¶ 24.) In her answer to the complaint, the defendant admits that Mr. Boyd applied for waiver services, but states that he applied for services in December 2008, not October 2008. (Answer ¶ 26.) Moreover, even if Mr. Boyd failed to follow application procedures or filed an application for one particular waiver and not another, failure to follow administrative formalities does not bear on whether an individual with a disability is qualified to receive services in an integrated setting. *See Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d at 333 n.44 (expressing doubt that failure to file a formal application "bears on whether individuals are qualified to receive services in a 'more integrated setting.'").

programs.[13] Defendant has produced evidence that the Elderly and Disabled waiver provides personal care services without any hourly limit. (Affidavit of Marilyn Chappelle ¶ 14.) Thus, that program can readily meet Mr. Boyd's needs for personal care services. Additionally, with respect to skilled nursing services, Alabama law contains a regulatory exception that permits a nurse or doctor to delegate such services to unlicensed personnel. Def.'s Resp. at 15-16 (citing regulation of Alabama Board of Nursing allowing a registered nurse to delegate tasks to a designated caregiver under certain circumstances); *see also* Ala. Code 1975 § 34-21-6 (providing that Chapter regarding practice of professional nursing "does not prohibit ... persons, including nursing aides, orderlies, and attendants, carrying out duties necessary for the support of nursing services, … or under the supervision of professional nurses licensed hereunder, nor gratuitous nursing of the sick by friends or members of the family….") Thus, Mr. Boyd's need for limited skilled nursing services in connection with his catheter and bowel program could be delegated to another person, such as a home health attendant, a service provided in the State's Medicaid plan. *See* 42 U.S.C. § 1396a(a)(10)(D) ("A state plan for medical assistance must … provide … for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services"); *see also Alabama Medicaid Covered Services and Co-payments* (attached as Exhibit D) (describing home health services offered in the State plan for recipients who have "an illness, disability or injury that keeps him or her from leaving home without special equipment or the help of another person."). Moreover, under 42 C.F.R. § 440.70, a state's home care program must include "medical supplies, equipment and appliances." *Townsend*, 328 F.3d at 522 (citing 42 C.F.R. § 440.70). Defendant fails to explain why the

[13] Defendant cites no authority that expressly precludes serving an individual in more than one waiver so long as there is no duplication of payment and the services are coordinated.

medical supplies, equipment and appliances provided for in the State's home care program would not be sufficient to meet Mr. Boyd's needs.

Defendant's argument that the requested relief is not a reasonable modification rests primarily on the fact that she cannot "unilaterally amend any Medicaid waiver program." Def.'s Resp. at 65. But states routinely apply to CMS to amend their waiver programs in order to comply with the integration mandate. *See Knowles v. Horn*, 2010 WL 517591 (N.D. Tex., Feb. 10, 2010) (citing to *Grooms v. Maram*, 563 F. Supp. 2d 840, 857 (N.D. Ill., 2008) ("[T]he federal government has not denied a single waiver application in the last ten years. Defendant here presents no basis to believe the federal government would deny the State's application for an amendment in this case and the court will not concoct one.").[14] Several courts have recognized that modifying a Medicaid waiver program to comply with the integration mandate is reasonable. In a similar case challenging the State of Illinois' limits on the amount of services under a waiver program, the Seventh Circuit determined that requiring the state to modify the services provided via its waiver program would not by itself be a fundamental alteration. *See Radaszewski ex rel. Radazewski v. Maram*, 383 F.3d 599, 611 (7th Cir. 2004). In another similar case, a district court held that requiring the state to amend its waiver application in order to continue to provide the level of services plaintiff required to remain living in the community would not be a fundamental alteration. *Grooms v. Maram*, 563 F. Supp. 2d 840, 857 (N.D. Ill. 2008). Moreover, as

[14] The only recent exception to this trend was a rejection by CMS of a request by the State of Missouri that would have resulted in the state serving more people in segregated settings. Missouri had submitted a request to increase the population served in its mental retardation/developmental disabilities waiver program by funding placements into residential units clustered on the grounds of a large State-operated institution. *See* Ohio Legal Rights Service, *CMS Rejects Application to Use Waiver to Fund Group Homes In Missouri*, Aug. 11, 2010, available: http://www.olrs.ohio.gov/news/missouri-cms-waiver-denial. CMS rejected the request because "[u]nder the proposed amendment, Missouri would not provide services that permit individuals to avoid institutionalization, but would [instead] serve individuals in an institutional setting." *Id.*

discussed, *supra* pp. 8-9, CMS itself has recognized that a state may need to amend its waiver programs to comply with the ADA.

It is the defendant's burden to establish that the requested relief would fundamentally alter its service program. *See Olmstead*, 527 U.S. at 604; *Frederick L. v. Dept. of Public Welfare*, 364 F.3d 487, 492 n. 4 (3d Cir. 2004) ("*Frederick L. II*"); *Disability Advocates, Inc.*, 653 F. Supp. 2d at 267; *Haddad* Op. at 33-36. Defendant fails to meet this burden. The defendant has put forward no evidence that providing services to Mr. Boyd in the community would compel cutbacks in services to others with disabilities or otherwise alter the nature of the State's program. In fact, the only evidence of estimated costs in the record – defendant's application to the federal Centers for Medicare and Medicaid Services for approval of its Elderly and Disabled Waiver Program – indicates that the cost of care in the community is much less than the cost of care in a nursing facility. In that application, the State represented that the average yearly cost of care for a Medicaid recipient in a nursing facility over a five-year period is approximately $36,455.00, whereas the average yearly cost of care in the community for that same time period amounted to approximately $22,876.00. *See* E/D Waiver Application, referenced *supra* p.5., Appendix J-1:1

Even if, assuming *arguendo*, providing services to Mr. Boyd in the community increases the state's administrative burden or cost, that alone does not constitute a fundamental alteration of the State's Medicaid program. *See Pa. Prot. & Advocacy, Inc. v. Dep't of Pub. Welfare*, 402 F.3d 374, 380-81 (3d Cir. 2005) (explaining that "it would have been legal error for the District Court to find a fundamental alteration solely on the basis of budgetary constraints"); *Frederick L. II*, 364 F.3d at 501 (vacating district court ruling in favor of state defendants where fundamental alteration defense was premised on the state's limited economic resources and did not

demonstrate a commitment to action with regard to community placement in a manner for which the state can be held accountable by the courts). *Townsend* 328 F.3d at 520 (Remanding for further factual development but explaining that budgetary considerations are insufficient to establish a fundamental alteration defense and focusing instead on "whether [the asserted] extra costs would, in fact, compel cutbacks in services to other Medicaid recipients"); *Fisher* , 335 F.3d at 1182-83 ("the fact that [a state] has a fiscal problem, by itself, does not lead to an automatic conclusion that [the provision of community-based services] will result in a fundamental alteration …. If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed.")

Moreover, to invoke the fundamental alteration defense, a public entity must demonstrate that it has a "comprehensive, effectively working plan to address unnecessary institutionalization." *Olmstead*, 527 U.S. at 605-06; *Pa. Prot. & Advocacy, Inc.*, 402 F.3d at 381-82 (the Court's Olmstead opinion allows for a fundamental alteration defense only if the accused agency has developed and implemented a plan to come into compliance with the ADA and [the Rehabilitation Act]"); *Disability Advocates, Inc.*, 598 F. Supp. 2d at 339 ("If a state does not make a genuine attempt to comply with the integration mandate in the first instance, it cannot establish that compliance would be a fundamental alteration of its programs and services…."); *see also Haddad* Op. at 35-36 (granting preliminary injunction to plaintiff seeking waiver services and finding that defendants' fundamental alteration defense was not sufficiently supported where they failed to show they have a comprehensive, effectively working plan in place to address unnecessary institutionalization).

Here, defendant has provided no facts suggesting there is an effective plan in place to address unnecessary institutionalization. To the contrary, she references the existence of many other people who, like Mr. Boyd, desire to move out of the nursing home and receive services in the community. *See* Def.'s Resp. at 4 ("[I]t may be assumed that Mr. Boyd's desire to move out of the nursing home is shared by almost everyone else who lives there."). Defendant asserts, without any support, that Mr. Boyd would be "jumping line" if he were to gain entry to the Elderly and Disabled Waiver, but she provides no facts concerning the length of any waiting list, the rate that individuals on the list are placed in community-based programs, or Mr. Boyd's placement on any wait list. Nor does the defendant provide any information with respect to the decline in the number of persons, like Mr. Boyd, who are unnecessarily confined in nursing homes. Courts have found such factors necessary to establish a finding that a defendant has an effectively working plan in place. *See Arc of Washington v. Braddock*, 427 F.3d 615, 621 (9th Cir. 2005) (citing waiting list with turnover, increased slots, increases in community-based services expenditures and declining institutionalized populations); *Frederick L. v. Dept. of Pub. Welfare of Pa.*, 422 F.3d 151, 157-160 (3d Cir. 2005) (deinstitutionalization plan must be specific and measurable and include time-frames and rates of community transition); *Haddad* Op. at 34 (granting preliminary injunction where defendants failed to provide "the most basic factual information in regard to the waiver program and its waiting list."). Given the lack of any facts suggesting that defendant has any plan in place to address unnecessary institutionalization, she cannot establish that granting preliminary injunctive relief to Mr. Boyd would be a fundamental alteration. Accordingly, Mr. Boyd is likely to prevail on the merits of his claims.

II. Plaintiff Will Suffer Irreparable Harm Without A Preliminary Injunction

Defendant discounts the harm that Mr. Boyd's institutionalization has caused and will continue to cause him. Def.'s Resp. at 11, 65-67. As a 34-year-old man confined indefinitely to a nursing home, Mr. Boyd is isolated from his peers and cut off from his community. All of the activities of the nursing home are targeted to people much older than him, and he is "deprived of the simple pleasure of being around people [his] own age with similar interests and activities." (Boyd Am. Decl. ¶ 21.) Given the regimented nature of the nursing home, Mr. Boyd's opportunities for social contact are extremely limited. He must be present at the institution at specific hours, and he is limited by the schedule of activities in the home. (Id. ¶ 20.) Furthermore, he has virtually no privacy, and he is surrounded by constant noise and commotion. (Id. ¶ 22.) As a result of these and other institutional characteristics of the nursing home, Mr. Boyd has suffered and continues to suffer irreparable harm.

Many courts have recognized that the harms associated with institutionalization are irreparable. For instance, in *Haddad*, the court granted the plaintiffs's motion for preliminary injunction, finding that she had "clearly established that she is at risk of irreparable injury if required to enter a nursing home." *Haddad* Op. at 37. *See also Washington v. DeBeaugrine*, 658 F. Supp. 2d 1332, 1339 (N.D. Fla. 2009) ("Withholding benefits essential to a disabled person's ability to remain in the community rather than in an institution rather obviously would constitute irreparable harm."); *Long*, 2008 WL 4571903, at *2 (forcing individual to leave his community placement and enter a nursing home "will inflict an enormous psychological blow"); *Marlo M. v. Cansler*, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) (if plaintiffs lost community services they would "suffer regressive consequences if moved [to a nursing home], even temporarily"); *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008)

(institutionalization would be detrimental to [plaintiffs'] care, causing, *inter alia*, mental depression, and for some plaintiffs, a shorter life expectancy or death").

Furthermore, Mr. Boyd's unnecessary institutionalization has caused him to suffer the very harms recognized by the Supreme Court in *Olmstead*. As a result of his confinement in a nursing home, Mr. Boyd's opportunities for "social contact, work options, economic independence, educational advancement, and cultural enrichment" are severely limited. *See Olmstead*, 527 U.S. at 600-01. Mr. Boyd's progress in his graduate degree program has been and will be inordinately delayed because his current placement in a nursing facility requires him to limit enrollment to two classes per semester. (Id. ¶¶ 13-16.) Further, he is unable to enjoy University activities that are the bedrock of participation in an enriching academic environment – athletic events, author readings, or theatrical and musical performance. (Id. ¶ 15).

The harms that Mr. Boyd has suffered and will continue to suffer cannot be adequately remedied by a future order of this Court.

III. The Balance of Hardships Weighs in Plaintiff's Favor

The balance of harms clearly lies in plaintiff's favor. The hardships that plaintiff currently endures as a result of his institutionalization far outweigh any potential hardship to the State. The defendant has not identified any in costs that would be incurred by serving Mr. Boyd in a community-based setting rather than a nursing home. In fact, the evidence in the record demonstrates that the State would experience cost savings. Even if there were some costs associated with the relief, any financial burden that defendant might incur will likely be offset by the cost savings that accrue from avoiding long-term institutional care and enabling Mr. Boyd to pursue his career and gain economic independence. *See V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1122 (N.D. Cal. 2009) (granting preliminary injunction where the risk of unnecessary

institutionalization outweighed the financial burden of the state during a fiscal crisis); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1177 (N.D. Cal. 2010) (state's fiscal crisis did not outweigh harm to persons with disabilities facing a reduction in services); *Haddad* Op. at 37 (granting mandatory, preliminary injunction and finding that balance of harms weighed in favor of plaintiff). Thus, the balance of hardships clearly tips in plaintiff's favor.

IV. Granting This Preliminary Injunction is in The Public Interest

The public interest in community integration weighs heavily in favor of granting a preliminary injunction. *Haddad* Op. at 38 ("[T]he public interest favors preventing the discrimination that faces Plaintiff so that she may avoid unnecessary institutionalization … [and] upholding the law and having the mandates of the ADA and Rehabilitation Act enforced ….). There is a strong public interest in eliminating the discriminatory effects that arise from segregating persons with disabilities into institutions when they can be appropriately placed in community settings. As *Olmstead* explained, the unjustified segregation of persons with disabilities can stigmatize them as "incapable or unworthy of participating in community life."[15] 527 U.S. at 600. In *Long*, the court relied on this reasoning to hold that the public interest favored allowing the plaintiff to "remain in the community rather than be isolated in the nursing home":

> If, as it ultimately turns out, treating individuals like [plaintiff] in the community would require a fundamental alteration of the Medicaid program, so that the Secretary prevails in this litigation, little harm will have been done. To the contrary, [plaintiff's] life will have been better, at least for a time…

Long, 2008 WL 4571903, at *3.

[15] *See also* U.S. Amicus Brief in *Olmstead* at 16-17, citing to 136 Cong. Rec. H2603 (daily ed. May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared," and "only by breaking down barriers between people can we dispel the negative attitudes and myths that are the main currency of oppression.").

CONCLUSION

For the reasons stated above, the Court should grant Plaintiff's Motion for Preliminary Injunction. With the Court's permission, counsel for the United States will be present at the preliminary injunction hearing on October 13, 2010.

DATED: October 12, 2010

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that on October 12, 2010, a copy of foregoing was filed electronically with the Clerk of the Court using the CM/ECF system, which will electronically send a copy of the same to the following: James Tucker (jtucker@adap.us.edu), Lonnie J. Williams (lwilliams@adap.us.edu), Steve Gold (stevegoldada@cs.com), 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).

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Exhibit A

SECTION 1915(c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.____ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ aged (age 65 and older)

b. X disabled

c.____ aged and disabled

d.____ mentally retarded

e.____ developmentally disabled

f.____ mentally retarded and developmentally disabled

g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. X Waiver services are limited to the following age groups (specify):

Age 18 and above

b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

This waiver specifically provides services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60. The disease(s) or condition(s) are: quadraplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophies, spinal muscular atrophy, severe cerebral palsy, stroke, and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehon Syndrome.

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.____ Other criteria. (Specify):

e.____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of

this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of ∋1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.____ No c.__X__ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.__X__ Yes b.____ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.____ Yes b.__X__ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.__X__ Case Management

b.____ Homemaker

c.____ Home health aide services

d._X_ Personal Care Services

e.____ Respite care

f.____ Adult day health

g.____ Habilitation

____ Residential habilitation

____ Day habilitation

____ Prevocational services

____ Supported employment services

____ Educational services

h._X_Environmental Accessibility Adaptations

i.____ Skilled nursing

j.____ Transportation

k.____ Specialized medical equipment and supplies

l.____ Chore services

m._X_Personal Emergency Response Systems

n.____ Companion services

o.____ Private duty nursing

p.____ Family training

q.____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s.____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

t. X Other services (specify):

Assistive Technology, Minor Assistive Technology, Medical Supplies, Evaluations for Assistive Technology, Assistive Technology Repairs and Personal Assistance Services

u.____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid Agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. N/A When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. N/A Meals furnished as part of a program of adult day health services.

c. N/A When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid Agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a._X_ Yes b.____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.____ Yes b._X_ No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of April 1, 2005 is requested.

20. The State contact person for this request is Latonda Cunningham, who can be reached by telephone at (334) 353-4122.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:
Print Name:
Title:
Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

___X___The waiver will be operated by the Department of Rehabilitation Services, a separate agency of the State, under the supervision of the Medicaid Agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

_____The waiver will be operated by _____ , a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _X_ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

_X_ Other Service Definition (Specify):

Please See Attached Scope of Service Definition

b._X_ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are 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.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

___ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or

step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

A licensed practical nurse, licensed to practice nursing in the State.

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an

extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_X_ Other service definition (Specify):

Please See Scope of Service Definitions

c._X_Environmental Accessibility Adaptations:

_X_ 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. Such 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 of general utility, and are not of direct medical or remedial benefit to the individual, 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 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.

_X_ Other service definition (Specify):

Please See the Attached Scope of Service

d._X_Personal Emergency Response Systems (PERS)

___ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as

specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_X_ Other service definition (Specify):

Please See the Attached Scope of Service Definition

e._X_ Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Medical Supplies, Minor Assistive Technology, Assistive Technology, Evaluation for Assistive Technology, Assistive Technology Repair and Personal Assistance Services.

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Case Management				See Minimum Qualifications in Attached Scope of Services
Personal Care				See Minimum Qualifications in Attached Scope of Services
Environmental Accessibility Adaptations				See Minimum Qualifications in Attached Scope of Services
Medical Supplies				See Minimum Qualifications in Attached Scope of Services
Minor Assistive Technology				See Minimum Qualifications in Attached Scope of Services
Assistive Technology				See Minimum Qualifications in Attached Scope of Services

Evaluations for Assistive Technology				See Minimum Qualifications in Attached Scope of Services
Assistive Technology Repairs				See Minimum Qualifications in Attached Scope of Services
Personal Emergency Response System				See Minimum Qualifications in Attached Scope of Services
Personal Assistance Services				See Minimum Qualifications in Attached Scope of Services

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

N/A

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_X_ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

___ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid Agency.

SCOPE OF SERVICE DEFINITIONS
FOR THE
STATE OF ALABAMA INDEPENDENT LIVING WAIVER
(SAIL)

CASE MANAGEMENT SERVICES
SAIL WAIVER

Case Management Services will assist individuals who receive waiver services in gaining access to 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. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services.

Case management activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain a person in the community.

Case managers shall be responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care.

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of the Plan of Care as specified in the waiver document.

A. Objective:

The objective of case management is to assist clients with making and managing their decisions regarding long term care. It also ensures continued access to appropriate, available and desired services by the client.

Medicaid will not reimburse for activities performed which are not within the Scope of Services. Transitional Case Management should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

B. Description Of Service To Be Provided

1. The unit of service will be per 15 minute increments commencing on the date that the client is determined eligible for the State of Alabama Independent Living (SAIL) Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required each month in addition to any other case management activities. A unit of service for Case Management that assists in the transitioning of individuals from institutional settings into the community will be per 15 minute increments beginning on the first date the case manager goes to the institution to complete an initial assessment.

There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor.

2. Services may or may not be provided on those weekends and/or days designated as Alabama State legal holidays. Case managers have 13 paid holidays annually. They may elect to request approval from the State Coordinator to work on a holiday or weekend, i.e., personal illness, illness of a family members, personal problems, etc., that will prevent them from doing their required monthly visit.

3. The intensity of case management services provided to each client is dependent upon the individual client's needs, as set forth in the Plan of Care which is developed by the case managers in conjunction with the client, primary caregiver, and/or family member. At least one visit is required monthly in addition to any other case management activities.

4. Case management includes the following activities: initial assessment; developing, monitoring and evaluating the Plan of Care; authorizations for waiver services (including transitional, initial, changed, interrupted, redetermination and terminated authorizations); referrals to other agencies as needed; service coordination; case monitoring, monthly or more often as appropriate; review and initial the plan of care every 60 days with the client, responsible party, and/or knowledgeable other; re-evaluation; level of care at redetermination; case termination and transfer; and establish and maintain client case record.

5. All SAIL Waiver recipients will receive Case Management Services.

6. Case Management is a waiver service and must be on the Plan of Care. Waiver services not listed on the Plan of Care and the Service Authorization Form will not be paid.

C. Intake Screening

1. Prior to waiver assessment, all potential clients are screened to determine their eligibility and desire for waiver participation. These activities are distinct from case management but are included in this Scope of Service since they are preliminary activities necessary for waiver enrollment. With the exception of case management activities for individuals transitioning from an institution into the community, case management activities provided to a client prior to waiver approval are considered administrative.

2. Intake screening activities will be conducted by case managers.

3. Case management can be provided to individuals transitioning from an institution to the

community for up to 180 days prior to discharge. When this service is provided to transition clients, assistance will be exercised in facilitating and coordinating community-based services from institutional settings. Referrals may be received from but not limited to:

- Client
- Family members
- Nursing facility staff
- Physician

The following tools will be provided by the operating agency for use by case managers assisting in the transition of individuals from institutions into the community:

- An interview tool for residents interested in transition to assess preferences, service support needs and available community resources;
- An overview and explanation of the person-centered planning process;
- A timeline of recommended activities for the case manager to consider before the individual transitions from the institution and during the first month after the individual leaves the institution.

*If the person is not eventually served in the community due to death, the individual's choice is not to receive waiver services, or loss of Medicaid eligibility, etc, the case management activities may be billed as Administrative Case Management.

Case Management service includes the following activities:

a. Assessment - a method of determining a client's current long term care needs through the use of a comprehensive assessment instrument. The assessment instrument is utilized to assess each individual client's functional, medical, social, environmental, and behavioral status. Information obtained during the assessment process should be adequate to make a level of care decision and for case managers to gather information for an initial Plan of Care.

b. Level of Care Determination - the process of identifying the extent of a person's medical and functional disability in keeping with the Alabama Medicaid Agency Level of Care criteria. By applying these criteria, a client's level of care can be determined.

For residents in the nursing facility interested in transitioning into the community, the case manager should thoroughly review referrals and intake information. This process will take place during the 180 consecutive days transition period. An initial face-to-face introductory interview to discern each resident's interest in leaving the nursing facility will be performed.

A visit can be made to discuss the overall medical and physical condition of the resident and also evaluate all community resources available to meet the resident's needs. This meeting will also include the resident, family or sponsors to assist in developing a Transitional Plan of Care for the move to the community.

A visit is made to finalize the Transitional Plan of Care and to assure all involved are aware of the services available to maintain the client in the community.

Following referral and intake, the case manager makes a face-to-face visit with the client for evaluation and completion of the assessment form. To clarify the assessment information, the case manager may consult with the client and/or family, and physician, with regard to medical, behavioral, functional and social information.

Once the Case Manager has adequate information for a sound level of care determination an initial Plan of Care is completed. The complete application packet is submitted to the Alabama Medicaid Agency. The assessment information is evaluated by a RN and a level of care determination is made in accordance with the Level of Care Criteria for Alabama Medicaid Agency Long Term Care Services. If the RN is unable to make a level of care decision, a referral must be made to the Medicaid staff physician. Justification for level of care determination must be properly documented.

c. Choice of Institution or Community Care - Initially, each client must make a written choice between institutional or community care, which will remain in effect until such time as the client changes his/her choice of service location. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, certification and/or services should not be denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice should be carefully documented. A responsible party should be encouraged to work with the case manager in developing an appropriate Plan of Care.

When a capable client is presented with realistic options and ultimately chooses community placement or institutional placement, the case manager should support that decision. However, when the client's choice is not realistic and the choice puts the client in an unsafe situation, the case manager should point out to the client that the choice is not in keeping with his/her service needs. Once this has been done, the service choice is still the client's decision. It is important to document this discussion and continue to work with the client toward the safest possible Plan of Care.

For transitioning clients, the case manager should obtain from page 3 of the HCBS-1 application the Certificate of Choice Statement signed by the client

indicating the individual's desire to transition into a community setting.

d. Eligibility Determination

1. Verifying client's financial eligibility is an important function of the case manager. If a client is seeking waiver services, but is not currently SSI eligible and it appears that he/she may qualify, he/she should be referred to the local social security office, unless a recent application has been made. If a client is not SSI eligible due to excess income of client, parent(s) or spouse, a financial application (Form 204) must be submitted along with the waiver application form. The case manager should always inform the client/family of the application process. Medicaid (financial) eligibility must be verified monthly.

2. Financial eligibility should be established as soon as practical for individuals transitioning from an institution to the community.

3. Applicants must reside in a nursing facility for at least 90 days before the individual will be considered a candidate for transition.

4. A physician must provide a statement that the client can be maintained in a community setting/least restrictive setting. Prior to the transition of the individual from the institution, a final team meeting should be scheduled to ensure coordination of all transition activities.

e. Developing a Plan of Care for Case Management and Transitional Case Management - both include a comprehensive review of the client's problems and strengths. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development should include participation by the client and/or family/primary caregiver, and case manager. The Plan of Care development process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized.

Development of the Plan of Care for all individuals transitioning from the institution is based on individual needs. Development of the Plan of Care should include participation by the individual's family/sponsor and case manager. This process will provide information for all individuals to make informed choices regarding available community services and support. During the transition period, special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the client to make sure services are appropriate for client's needs.

Transitional Case Management also includes the development of a realistic and thorough Plan of Care and its implementation in the community involves numerous

contacts and extensive planning and coordination.

The Plan of Care development must include exploration of the resources currently utilized by the client, both formal and informal, as well as those additional services which may be available to meet the client's needs. Service planning includes a visit with the client and contact with the family members and/or existing potential community resources.

f. Service Coordination - will be accomplished by the case manager along with input from the client/family/caregiver, and other involved agencies/parties as needed. All services needed by the client will be included in the Plan of Care implemented by the case manager.

Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service contracts will be updated to reflect any changes in service needs.

g. Monitoring - each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the client to make sure services are appropriate for client's needs.

Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

Clients and/or responsible relatives shall be instructed to notify the case manager if services are not initiated as planned, or if the client's condition changes. However, it is the responsibility of the case manager to promptly identify and implement needed changes in the Plan of Care .

h. Re-determination - A complete review of every case will be done at least annually. The review shall include completion of the same comprehensive standard assessment used in the initial assessment. The client's choice of location will be verified, Medicaid eligibility verified, and a new Plan of Care developed by the case manager.

It may be necessary due to reported or observed changes in a client's condition to update the assessment as needed but at least annually. This shall be done by

completing a new assessment form. An update shall always be accompanied by a reevaluation of the client's level of care and service needs. The Plan of Care will be revised as necessary.

i. Plan of Care - After the Plan of Care is completed and implemented; it will be evaluated for its effectiveness. The time frame for this evaluation will depend on numerous factors and will vary, but will always be completed at least annually corresponding with the client's waiver eligibility dates.

An evaluation of the Plan of Care includes a review of the previously set goals to determine if they have been met. This evaluation shall take place at the end of the time frame set for the goal to be achieved. The family, providers and caregivers may be contacted for their input in evaluating the effectiveness of the Plan of Care and any changes that have occurred in the client's condition or support system.

The Plan of Care must be reviewed and initialed every sixty (60) days by the case manager. During the 60-day review, the case manager will review the Plan of Care with the client, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are written in by the case manager, to be later updated. A copy of the Plan of Care remains in the client's home.

j. Initial Contract of Waiver Services - waivered services will be based on a client's need as documented in the Plan of Care. The Plan of Care should be a clear, factual representation of the client's need and support the rationale and appropriateness for a service contract.

The case manager will issue a written service contract to a provider to initiate a waivered service. The contract should be specific and accurate including the number of units per visit and number of days per week, which services are to be provided.

The amount, frequency and duration of a service depend on the client's needs, but may not exceed the statewide average cost for the same level of care in a nursing home. In some cases, a client may require services, which exceed the statewide average cost of institutional care. These cases should be monitored closely to ensure community services are appropriate and that client's health and safety are protected.

k. Changes in Services within Contract Period - Services may be initiated or changed at any time within a contract period to accommodate a client's changing needs. Any change in waivered services necessitates a revision of the Plan of Care. The revised Plan of Care must coincide with the narrative explaining the change and a new Service Contract Form should be submitted by the Case Manager.

1. Termination of Waivered Services - Any time a client no longer requires a service, the service must be officially terminated. Advance notice and appeal rights regarding the reduction, suspension or termination of a waiver service must be granted to the client. Waivered services may be terminated at any time during the contract period. Termination of a service will necessitate a revision of the Plan of Care. A Service Authorization Form indicating the service is terminated must be forwarded to each DSP.

m. Case Termination and Transfer - When an applicant or a current waiver client relocates to another county, the case is transferred to the receiving case manager. The transferring case manager prepares all necessary materials and makes initial contact with the receiving case manager. The receiving case manager is responsible for coordinating the continuation of the client's waiver services.

Termination involves all activities associated with closing a waiver case when a client exits the program for specified reasons. When a client is to be terminated from the Waiver Program, all service providers should be notified of the client's discharge in a timely manner. At the point of termination, the case manager should assist as much as possible in making alternative arrangements in meeting the client's needs.

n. Maintaining and Documenting Case Record - Adequate documentation is one of the most important tools in determining the success of the waiver program. It is vital to maintain documentation on all aspects of the waiver: from the initial data gathering process, delivery of services, complaints and grievances from recipients and providers, billing and payment records, levels of care, plans of care, case management narrative and cost effectiveness data. This information is used to assure that the State is operating the waiver in accordance with the approved waiver document and that waiver services are appropriate for the individuals being served.

D. Case Management Qualifications

1. Routine, ongoing, case management services will be conducted by case managers who meet minimum qualifications below:

a. Professionals having earned a Master of Arts degree or a Master of Science degree, preferably in Rehabilitation Counseling or related field, from an accredited college or university, or having earned a degree from an accredited School of Nursing. Transitional Case Management Services may be delivered by a SAIL employee possessing a BS degree in social work, psychology or related field who has provided services as an Independent Living Specialist.

b. Transitional Case Management Services will also be conducted by case managers who meet the minimum accredited college/university qualifications described above.

c. Demonstrate capacity to provide all core elements of case management:

(1) assessment,
(2) Plan of Care development,
(3) linking/coordination of services,
(4) monitoring,
(5) reassessment/follow-up, and
(6) documentation.

d. Demonstrate case management experience in coordinating and linking such community resources as required by the SAIL Waiver target population.

e. Demonstrate experience with the waiver target population.

f. Capacity to document and maintain individual case records in accordance with state and
federal requirements.

g. Demonstrate ability to assure a referral process consistent with Section 1902a (23) the Social Security Act, freedom of choice of provider.

2. All case managers will be required to attend a Case Managers' Orientation Program provided by the operating agency and approved by the Alabama Medicaid Agency and attends on-going training and in-service programs deemed appropriate.

a. Initial orientation and training must be completed within the first three (3) months of case manager employment. Any exception to this requirement must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the case manager's personnel file.

b. The operating agency will be responsible for providing a minimum of six (6) hours relevant in-service training per calendar year for case managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year. Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location and outcome of training. Topics for specific in-service training may be mandated by the Alabama Medicaid Agency. Annual in-service training is in addition to the required orientation and training discussed in item 2a. Proof of training must be recorded in the personnel file. The operating agency shall submit proposed programs to Medicaid at least forty-five (45) days prior to the planned implementation. Any exception must be approved by the Alabama Medicaid Agency.

3. The operating agency must have a Quality Assurance Program for case management services in place and approved by the Alabama Medicaid Agency. The Quality Assurance program shall include case manager record reviews at a minimum of every ninety (90) days. Documentation of quality assurance reviews and corrective action must be maintained by the operating agency and will be subject to review by the Alabama Medicaid Agency.

4. Documentation and Record-keeping

The operating agency shall maintain a record-keeping system that documents the units of case management service delivered. Case management documentation shall be made available upon request to Medicaid, or other agencies as designated in the contractual agreement.

The operating agency shall maintain a file on each case manager, which shall include the following:

1. Each employee's application for employment
2. Job description
3. Record of pre-employment and in-service training
4. Initial orientation/training and annual in-service
5. Evaluations
6. Supervisory visits and case management quality assurance reports
7. Work attendance
8. Reference contacts.

The operating agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

5. Rights , Responsibilities and Service Complaints

1. The operating agency has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The operating agency will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will

provide information about how to register a complaint with the case manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against a case manager will be investigated by the operating agency and documented in the client's file.

b. The case manager supervisor will contact the case manager by letter or telephone

about any complaint against the case manager and any recommended corrective action.

c. The case manager supervisor will take the necessary action and document the action taken in the client's and employee's files.

d. All other complaints to be investigated will be referred to the case manager who will take appropriate action.

e. Complaints from individuals transitioning from the institution will be referred to the case manager who will take the appropriate action to resolve the complaint.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

6. Policy and Procedures Manual

In addition to the foregoing, providers of case management services will adhere to the current SAIL Policy and Procedures Manual and all subsequent revisions.

F. Administrative Requirements

1. The operating agency shall designate an individual to serve as the waiver coordinator who will ensure that only qualified employee personnel are employed and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated coordinator will have the authority and responsibility for the direction of the waiver service program for the operating agency. The operating agency, in writing, shall notify the Alabama Medicaid Agency within three (3) working days in the event of a change in the coordinator, address, telephone number, or of an extended absence of the coordinator.

2. The operating agency will maintain an organizational chart indicating the line of authority and responsibility, and make it available to the Alabama Medicaid Agency upon request.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The operating agency will maintain a policy and procedures manual to describe how activities will be performed in accordance with the terms of this contract and include the organization's emergency plan. The Alabama Medicaid Agency must approve all policies and procedures.

PERSONAL CARE SERVICES
SAIL WAIVER

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are 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.

Personal care must be provided by an individual that is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

A. Objectives:

The objective of the Personal Care (PC) Service is to maintain and promote the health status of clients through home support, health monitoring, support and assistance with activities of daily living.

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

B. Provider Experience

Agencies desiring to be a provider of PC services must have demonstrated experience in providing PC or a similar service to the Operating Agency (OA).

C. Description Of Services To Be Provided

1. The Unit of Service will be per 15 minute increments of direct PC service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Provider Contract. The amount of time authorized does not include provider transportation time to and from the client's residence.

2. The number of units and services provided to each client is dependent upon the individual's need as set forth in the client's Plan of Care established by the Case Manager. Personal Care Services may be provided for a period not to exceed 100 units (25 hours) per week and not to exceed a total of 5,200 units (1300 hours) per waiver year (April 1 –March 31) in accordance with the provider contracting period. Individuals already receiving more that

100 units per week will continue to receive services based on their need as verified in the

Plan of Care. (Services may also be reduced based their on need.)

Medicaid will not reimburse for activities performed which are not within the Scope of Services.

2. The Direct Service Provider (DSP) shall provide its regular scheduled holidays to the Operating Agency (OA), and the DSP shall not be required to furnish services on those days. The DSP agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation.

3. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the case manager.

4. PC services include:

a. Support for activities of daily living, e.g., provided to the recipient and not family members:
-bathing
-personal grooming
-personal hygiene
-meal planning and preparation
-assisting clients in and out of bed
-assisting with ambulation

b. Home Support that is essential to the health and welfare of the recipient, e.g.
-light cleaning
-light laundry
-home safety

c. Basic monitoring of the client, such as skin condition while bathing, excessive sweating, abnormal breathing, abnormal lethargy, and recognition of emergencies.

d. Medication monitoring, e.g., the type that would consist of informing the client that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the PCW is responsible for giving the medicine; however, it does not preclude the PCW from handing the medicine container to the client.

e. Under no circumstance should any type of skilled medical service be performed by the PCW.

f. Personal Care services are not an entitlement. It is based on the needs of the individual client.

D. Staffing

The DSP must employ or may make sub-contractual arrangements for a Registered Nurse.

1. The registered nurse(s) must meet the following requirements:

a. Currently licensed by the Alabama State Board of Nursing to practice nursing.

b. Must pass a statewide and local background check.

c. At least two (2) years experience as a registered nurse in public health, hospital or long term care nursing.

d. Make the initial visit to the client's residence prior to the start of PC services for the purpose of reviewing the Plan of Care and giving the client written information regarding advance directives.

e. Current verification of an annual TB Skin Test must be in the employee's personnel record.

The DSP may employ or may make sub-contractual arrangements for a Licensed Practical Nurse who must meet the following requirements:

2. A licensed practical nurse(s) must work under the supervision of the registered nurse and must meet the following requirements:

a. Currently licensed by the Alabama State Board of Nursing to practice nursing.

b. At least two (2) years experience as a licensed practical nurse in public health, hospital or long term care nursing.

c. Must pass a local and statewide background check.

d. Capable of evaluating the PCW in terms of his or her ability to carry out assigned duties and his/her ability to relate to the client.

e. Ability to assume responsibility for in-service training for PCWs by individual instruction, group meetings or workshops.

f. Current verification of an annual TB Skin Test must be in the employee's personnel record.

3. PCWs who meet the following qualifications and requirements:

a. Must have references which will be verified thoroughly.

b. Must pass a local and statewide background check.

c. Must be able to read and write.

d. Must have at least completed eighth grade.

e. Must be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

f. Must have no physical/mental impairment to prevent lifting, transferring, or providing any other assistance to the client.

g. Must assist client appropriately with daily living activities related to personal care.

h. Current verification of an annual TB Skin Test must be in the employee's personnel record.

i. Must complete a probationary period determined by the employer with continued employment contingent on completion of personal care in-service training program and client's satisfaction.

j. Must be employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

k. Personal care services provided by family members or friends may be covered only if the family members or friends meet qualifications for providers of care; there are strict controls to assure that payment is made to the relative or friends as providers only in return for personal care services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The case manager must have documentation in the client's file showing that attempts were made to secure other qualified providers before a family member or friend is considered. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent. The OA is responsible for reviewing these records and verifying there is proper supportive

documentation to the lack of qualified providers living in a remote area.

l. Personal Choices participants (Cash and Counseling Pilot Project) may hire legally liable relatives, as paid providers of the personal care services. However, restrictions do apply on participant living arrangements, when homes or property are owned, operated or controlled by a provider of services, not related by blood or marriage to the participant. (refer to: AL SPA 07-002; Attachment 3.1-A 1915 (J) vi.)

4. **Nursing Supervision**

PC services must be provided under the supervision of a nurse who meets the requirements of D. 1 a.- e. or D. 2. a.- f. and will:

a. Make visits to the client's residence after the initial visit by the registered nurse.

b. Be immediately accessible by phone and must be physically accessible within (60) minutes from the client's residence during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours if this position ceases to be filled.

c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.

d. Provide on-site (clients' place of residence) supervision of the PCW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW.

e. Observe each PCW with at least one (l) assigned client at a minimum of every six (6) months or more frequently if warranted by substandard performance of the PCW. This function may be carried out in conjunction with one of the 60-day supervisory visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file.

f. Assist PCWs as necessary as they provide individual personal care services as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

5. The following are the minimum training requirements for PCWs. The minimum training requirement must be completed prior to working with a client. The DSP is

responsible for providing/or conducting the training.

a. Personal care training program should stress the physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, and his/her property.

NOTE: The PC training program must be approved by the OA.

Minimum training requirements must include the following areas:

-Activities of daily living, e.g.,

. bathing (sponge, tub)
. personal grooming
. personal hygiene (client and Personal Care Worker)
. meal planning and preparation
. proper transfer technique (assisting clients in and out of bed)
. assistance with ambulation
. proper lifting techniques

- Home support, e.g.,

. light cleaning
. light laundry
. home safety

- Monitoring of the client, e.g.,

. observe for signs of change in the condition
. prompt client to take medications as directed
. basic recognition of medical problems/and medical emergency
. basic first aid for emergencies

- Record keeping, e.g.,

. a daily log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.

. summary prepared weekly by the PCW and reviewed at least once every two weeks by the supervising nurse.
- Communication skills

- Basic infection control

b. Proof of the training must be recorded in the personnel file.

c. The DSP will be responsible for providing a minimum of twelve (12) hours relevant in-service training per calendar year (The annual in-service training requirements can be done on a pro-rated basis). Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed four of the twelve in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

6. Personnel files:
Individual records will be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

An individual client record must be maintained by the DSP. The requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PC services within three (3) working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date as stated on the Provider Contract.

2. The DSP will notify the Case Manager within three (3) working days of the following client changes:

a. Client's condition has changed and the Plan of Care no longer meets client's needs or the client no longer appears to need PC services.

b. Client dies or moves out of the service area.

c. Client no longer wishes to participate in a program of PC services.

d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

3. The DSP will maintain a record keeping system which establishes a client profile in support of units of PC service delivered, based on the Service Provider Contract. The

DSP will arrange a daily log reflecting the personal care services provided by the PCWs for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or family member/responsible person if the client is unable to sign, and the PCW. In the event the client is not physically able to sign and the family member/responsible person is not present to sign, then the PCW must document the reason the log was not signed by the client or family member/responsible person. The daily log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

4. The DSP must complete the sixty (60) day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC services.

5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the PC services as authorized. Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be reported in writing on Medicaid's 'WEEKLY MISSED VISIT REPORT' form to the case manager on Monday of each week. A missed visit is as follows: When the client is at his/her residence waiting for scheduled services and the services are not delivered. The provider cannot bill for missed visits.

6. Whenever two consecutive attempted visits occur, the case manager must be notified. An attempted visit is when the PCW arrives at the residence and is unable to provide the assigned tasks because the client is not at his/her residence or refuses services. "The provider cannot bill for attempted visits."

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the administering agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.

8. The DSP will inform clients of their right to complain about the quality of PC services provided and will provide clients with information about how to register a complaint. Complaints which are made against PCWs will be assessed for appropriateness and investigation by the DSP. All complaints which are to be investigated will be referred to the Nurse Supervisor who will take appropriate action. The DSP must maintain documentation of all complaints and follow-ups.

9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PC services to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed and the service contract form submitted prior to the provision of PC services. The DSP must maintain documentation showing that it has complied with the requirements of this section.

10. The Case Manager will authorize PC services by designating the amount, frequency and duration of service for clients in accordance with the client's Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identifies PC duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the Case Manager to discuss the possibility of having these duties included in the Plan of Care and the Service Provider Contract. The decision to modify the duties to be performed by the PCW is the responsibility of the Case Manager, and the Plan of Care and the Service Provider Contract must be amended accordingly. This documentation will be maintained in the client records.

11. The Case Manager will review a client's Plan of Care within three (3) working days of receipt of the DSP's request to modify the Plan of Care.

12. The Case Manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating the services. The Case Manager must verify Medicaid eligibility on a monthly basis.

13. Under no circumstance should any type of skilled medical service be performed by a PCW.

14. No payment will be made for services not listed on the Plan of Care and the Service Provider Contract.

15. The DSP will retain a client's file for at least five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The DSP Agency will inform the client/responsible party of their right to complain about the quality of PC services provided and will provide information about how to register a complaint.

   a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

   b. All complaints which are to be investigated will be referred to the PCW

Supervisor who will take appropriate action.

c. The PCW Supervisor will take any action necessary and document the action taken in the client's and employee's files.

d. The PCW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

2. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP agency. The DSP agency shall notify the administering agency within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The agency organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. his information shall be readily accessible to all staff. A copy of this information shall be forwarded to the administering agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP agency and to the administering agency.

3. The DSP agency must have written bylaws or equivalents which are defined as "a set of rules adopted by the DSP agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the DSP agency and shall be provided to the administering agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the DSP agency. A listing of the members of the governing body shall be made available to the administering agency upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to the administering agency prior to the signing of the initial contract with the administering agency. The DSP agency must maintain an annual operating budget which shall be made available to the administering agency upon request.

7. The DSP agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP agency shall furnish a copy of the insurance policy to the administering agency.

8. The DSP agency shall ensure that key agency staff, including the agency administrator or the Nurse Supervisor, be present during compliance review audits conducted by Medicaid, the administering agency and/or its agents.

9. The DSP agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA) SAIL WAIVER

Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individuals, or which enables the individuals to function with greater independence in the home and without which, the recipient would require institutionalization. Such 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 recipient. 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 also excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

This service is necessary to prevent the institutionalization of the recipient. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Limits on EAA are $5,000 per waiver client for the entire stay on the waiver. Any expenditure in excess of $5,000 must be approved by the state coordinator and the Medicaid designated personnel. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

A. Objective:

The objective of Environmental Accessibility Adaptations Services (EAA) is to ensure the health, welfare and safety of the individuals which enables them to function with greater independence in their current living arrangements.

B. Provider Qualifications

EAA 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 code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor. If the contractor is not licensed, the case manager will ask the Rehabilitation Technology Specialist to do a final inspection to ensure compatibility with local building code.

C. Description Of Services To Be Provided

1. The SAIL Waiver program will pay for this service when items requested are not covered under the regular State Plan program and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA medical record on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. The adaptations shall not include any improvements to the home which are not of direct medical or remedial benefit to the client, such as floor covering, roof repair, central air conditioning, etc.

3. All services shall be provided in accordance with applicable state or local building codes, and ADAAG regulations. This service will be provided by a licensed contractor.

D. Conduct of Service

1. Environmental Accessibility Adaptations should be ordered and arranged for by the SAIL Waiver case manager. The case manager should consult with a Rehabilitation Technology Specialist (RTS) to assist when there is questionable doubt as to the construction of EAA. RTS may also be utilized in developing specifications and in obtaining final approval of completed modification adaptations.

   The case manager must make sure that all the requirements are met.

2. Environmental Accessibility Adaptations must be prior authorized and approved by Alabama Medicaid, or its designee and must be listed on the client's Plan of Care. The maximum amount for this service is $5,000 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of $5,000 must be approved by the state coordinator and the Medicaid designated personnel.

3. A PRESCRIPTION IS NOT REQUIRED FOR THIS SERVICE.

4. Upon completion of the service, the clients must sign and date a form acknowledging receipt of the service. If the client is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

MEDICAL SUPPLIES
SAIL WAIVER

Medical supplies includes devices, controls and/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, and 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.

Medical supplies are necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical Supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

A. Objective:

The objective of the Medical Supplies service is to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. Medical supplies ensure health and safety for the duration of usefulness of supplies. Medical supplies are necessary for the care and functional capabilities of the recipient in the home.

B. Provider Experience

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. The case manager must provide the participant with a choice of vendors in the local area of convenience.

C. Description Of Services To Be Provided

1. Medicaid will pay for a service when the service is covered under the SAIL Waiver and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. Medical supplies are necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.

3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.

4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

5. All items shall meet applicable standards of manufacture, design and installation. Supplies are limited to $1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

D. Conduct of Service

1. This service will only be provided when authorized by the recipient's physician.

2. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services.

3. Supplies and medications must be indicated on the recipient's Plan of Care, they must be medically necessary to maintain the recipient's ability to remain in the home
and live independently.

4. Reimbursement for medical supplies shall be limited to $1800.00 annually per recipient. Receipt for all supplies purchased must be kept in the recipient's case record.

5. The case manager must provide the recipient with a choice of vendors in the area. A signed Participant Choice of Vendor form should be placed in the case file and a copy provided to the participant. Services should not be denied due to an absence of the signature of the recipient.

6. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes.

MINOR ASSISTIVE TECHNOLOGY
SAIL WAIVER

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

Minor Assistive Technology is necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition. MAT does not include common over-the-counter personal care items. Items reimbursed with waiver funds shall be in addition to any medical supplies or devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Minor Assistive Technology is limited to $500.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

A. Objective:

The objective of Minor Assistive Technology is to increase the functional capabilities of a participant and to promote safety and prevent further deterioration of participant's medical status. This service is necessary to prevent institutionalization.

B. Provider Experience

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. Vendors providing MAT/devices should be capable of supplying and training in the use of minor assistive technology/device.

C. Description Of Services To Be Provided

1. Medicaid will pay for a service when the service is covered under the SAIL Waiver and is medically necessary. "Medically Necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. MAT/devices include those assistive aids necessary for the recipient to perform or assist in performing activities of daily living skills, and in prevention and monitoring of medical condition. PA IS NOT REQUIRED FOR THIS SERVICE.

3. MAT authorizations include, but are not limited to: shower chairs, specialized cushions, alternating pressure pad and pump, specialized mattresses, over the bed table, shampoo tray, reachers, lifter sling, transfer board, glucometer, green boots, urinal, ADL cuff-holders, elbow protectors or pads, hand splints, and specialized feeding utensils or additional medical supplies to maintain health and safety. MAT/devices must be prescribed by a physician.

4. Items reimbursed with waiver funds shall be in addition to any MAT/devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

5. MAT/devices are limited to $500.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipient.

D. Conduct of Service

1. This service will only be provided when authorized by the recipient's physician.

2. The case manager must provide the participant with a Participant Choice of Vendor list. The case manager must arrange with the vendor to provide the MAT for the participant.

3. A Participant Choice of Vendor form must be written and signed by the responsible person. The form should be placed in the case file and a copy provided to the participant.

4. If provided, Minor Assistive Technology must be included on the Plan of Care.

5. A prescription for service must be in writing from the physician. Providers must have an agreement with the Department of Rehabilitation Services and should be a provider of the Alabama Medicaid Agency.

6. A delivery ticket signed by the participant is required prior to payment.

ASSISTIVE TECHNOLOGY
SAIL WAIVER

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and is 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 acquisitions, selection, design, fitting, customizing, adaptation, application, etc. 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. This service is necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. All items shall meet applicable standards of manufacture, design and installation.

A. Objective:

The objective of Assistive Technology service is to increase, maintain or improve functional
capabilities or individuals with disabilities. It will also help ensure the health and safety for the recipient which enables them to function with greater independence in their current residence.

B. Provider Qualifications

Businesses providing Assistive Technology services will possess a business license. Vendors are responsible for orientation to the equipment.

C. Description Of Services To Be Provided

1. The SAIL Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each recipient must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.

2. Assistive Technology includes pieces of equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities.

3. The amount for this service is $15,000.00 per waiver recipient. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the Medicaid designated personnel.

4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric). The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

D. Conduct of Service

1. Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology before requesting prior approval.

2. To obtain Prior Authorization numbers for this service, the case manager must submit a copy of the following documents:

   a. Medicaid Prior Authorization Form (#342).

   b. Price quotation list from the company supplying the recipient with equipment and specifying the description.

   c. A copy of the physician's prescription. Copies must be legible.

3. Assistive Technology 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. The prior authorization packet is submitted to ADRS by the case manager and ADRS submits prior authorization requests using the Medicaid Prior Authorization Form (342).

   Prior authorization is also required for Transitional Assistive Technology. ADRS will submit the prior authorization request packet to the Alabama Medicaid Agency Long Term Care Project Development/Program Support Unit for review and coordination.

4. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

6. The case manager should secure an EOMB (Explanation of Medicare Benefits) from the vendor if Medicare can be applied towards purchase before the final payment will be processed for Assistive Technology. Explanation of benefits should also be secured if the recipient has other insurance.

EVALUATION FOR ASSISTIVE TECHNOLOGY
SAIL WAIVER

This service will provide for an evaluation and determination of the client's need for Assistive Technology. The evaluation must be physician-prescribed and be provided by a therapist licensed to do business in the State of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

A. Objective:

To maintain the recipient's health, safety and welfare through appropriate evaluation of the recipient's need for Assistive Technology. The physical therapist's evaluations will allow only medically necessary equipment/devices to be authorized by the Medicaid Agency. This service is necessary to prevent institutionalization.

The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

B. Scope Of Service Includes the Following Elements

Complete patient assessments related to various physical skills and functional ability including neuro-muscular, coordination and control, balance and ambulation. Take recommendations regarding appropriate Assistive Technology. Confer with the case manager and referring physician as needed. Maintain record of evaluation

C. Provider Qualifications

Graduate from an accredited Physical Therapy institution
Alabama license in Physical Therapy
Any qualified providers meeting qualifications must be enrolled as a provider with ADRS
No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of Assistive Technology equipment/devices

D. Conduct of Service

This service must be prescribed by the physician and arranged for by the case manager.

When applicable, 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 provided.

Reimbursement for this service will be the standard cost per evaluation as determined by Alabama Medicaid and ADRS.

The recipient must be given the choice of qualified enrolled providers for this service.

ASSISTIVE TECHNOLOGY REPAIRS
SAIL WAIVER

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items and services must meet applicable standards of manufacture, design and installation.

A. Objectives:

To prevent repair delays when it is determined by the case manager that repair(s) are needed to maintain the recipient's health, safety and welfare.

B. Provider Standards

Business providing these repairs will possess a business license. They will also be required to give a guarantee on work performed.

C. Description Of Services To Be Provided

1. The SAIL Program will pay for repairs on equipment previously purchased through the waiver.

2. The provider shall be responsible for replacement or repair of the equipment on 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 Alabama Department of Rehabilitation Services.

3. Repairs outside the warranty period will be reimbursed by ADRS.

4. The maximum amount for this service is $2,000.00 per recipient annually.

D. Conduct of Service

1. Repairs must be arranged for by the case manager. It must be documented in the Plan of Care and case narrative. Prior authorization is not required for this service.

2. The case managers must make sure the equipment is not:

a. Under warranty by manufacturer before using this service.

b. Not covered by any other third party insurance before using this service.

3. A copy of the guarantee should be in the recipient's file.

4. Reimbursement for repairs shall be limited to $2,000.00 annually per recipient. Receipts for all repairs must be kept in the recipient's case record. Repair total must not exceed the amount originally paid for the equipment or device.

E. Third Party Liability

The provider must make all reasonable efforts to collect from any other health insurance policy a Medicaid recipient may have. Any payment received from the insurance company must be shown on the Medicaid claim when submitted to ADRS. Failure by the provider to collect available third party payments may result in recoupment of these payments by ADRS.

PERSONAL EMERGENCY RESPONSE SYSTEMS (INSTALLATION) SAIL WAIVER

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

A. Objective:

The objective of PERS is to assist the recipients who live alone or who are alone for significant parts of the day and do not have a regular caretaker for extended periods of time.

B. Provider Experience

PERS Set-up will be provided by individuals who are trained to install this device for
specific consumers for whom services are being provided.

C. Description Of Services To Be Provided

1. The system is connected to a client's phone and programmed to signal a response center once a "help" button is activated.

2. The set-up fee is a one time installation charge. This portion of the PERS service must be prior authorized and approved by the Alabama Medicaid Agency or its designee.

3. By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

D. Conduct of Services

1. PERS should be ordered and arranged for by the SAIL Waiver case manager.

2. PERS must be prior authorized, approved by the Alabama Medicaid Agency or its designee and must be listed on the client's Plan of Care. The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.

3. Case managers must assure that the Prior Authorization packet contains the following information:

   a. Alabama Review and Authorization Request (PA Form 342).
   b. Approval by the Department of Rehabilitation Services for Vendor Providing the Service
   c. Price Quotation from the Vendor Providing the Service Specifying the Description of Personal Emergency Requested.
   d. A Prescription from the Physician.

5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service. If the client is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

SAIL WAIVER

This service will cover the monthly fee after the system has been installed. The same objective, provider experience, etc., for PERS (S5161-UB) will apply for this service.

PERSONAL ASSISTANCE SERVICE
SAIL WAIVER

PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities. These activities would be performed by the individual if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on and off the job.

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. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service will be sufficient enough to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in the amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A. Objective:

The objective of PAS is to provide a range of services designed to assist an individual with physical disabilities to perform activities on and off the job.

B. Provider Experience

Agencies desiring to be a provider of PAS must have demonstrated experience in providing PAS or a similar service to the Operating Agency (OA).

C. Description Of Services To Be Provided

1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to enter or to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.

2. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.

3. The PAS received by an individual will be based on the individual's needs. The number of hours must be stipulated on the Plan of Care and Service Provider Contract.

4. IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE.

5. PAS is required, but are not limited to assisting with:

In Home:
Routine bathing and toileting
Dressing and undressing
Preparation and consumption of food
Personal grooming
Getting in and out of bed
Laundry
Bladder and bowel care
Medication Monitoring

Outside Home/Job Site:
Shopping
Transportation to and from work
Eating
Toileting
Medication Monitoring
Banking/paying bills
Retrieving work materials that are out of reach
Entering or exiting doors
Distributing materials to different locations of the building when necessary.

D. Staffing

The Direct Service Provider (DSP) must provide all of the following and may make subcontractual arrangements for some but not all of the following:

1. A registered nurse(s) who meets the following requirements:

   a. Currently licensed by the Alabama State Board of Nursing to practice nursing

   b. At least two (2) years experience as a registered nurse in public health, hospital or long term care nursing

   c. Must pass a statewide and local background check

d. Capable of evaluating the PAS worker in terms of his or her ability to carry out assigned duties and his/her ability to relate to the client

e. Ability to assume responsibility for in-service training for the Personal Care attendants by individual instructions, group meetings or workshops

f. Current verification of an annual TB Skin Test must be in the employee's personnel record.

2. A Personal Care Attendant who meets the following qualifications and requirements:

a. Must have references which can be verified thoroughly and must show no adverse reports on local/statewide background check

b. Must have no physical/mental impairment to prevent lifting transferring, or providing any other assistance to the recipient

c. Must assist recipient appropriately with daily living activities as related to personal care

d. Be at least 21 years of age

e. Driver's license and proof of insurance

f. Must have at least a 10^{th} grade education, preferably, high school graduate or GED

g . Must be free from communicable diseases. Current verification of an annual TB Skin Test must be in the employee's personnel record.

h. Must be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

i. Must be employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

j. Must complete a probationary period determined by the employer with continued employment contingent on completion of a personal care in-service training program and client's satisfaction.

k. Personal Assistant services provided by family members or friends may be covered only if family members or friends meet qualifications for providers of care; there

are strict controls to assure that payment is made to the relatives or friends only in return for Personal Assistance Services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The case manager must have documentation in the client's file showing that attempts were made to secure other qualified providers before a family member or friend is considered. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent. The OA is responsible for reviewing these records and verifying there is proper documentation of lack of qualified providers living in a remote area

l. Personal Choices participants (Cash and Counseling Pilot Project) may hire legally liable relatives, as paid providers of the personal assistance services. However, restrictions do apply on participant living arrangements, when homes or property

are

owned, operated or controlled by a provider of services, not related by blood or marriage to the participant. (refer to: AL SPA 07-002; Attachment 3.1-A 1915 (J) vi.)

3. Nursing Supervision

PAS services must be provided under the supervision of the registered nurse who meets the PAS staffing requirements and will:

a. Make visits to the client's residence after the initial visit by the registered nurse.

b. Be immediately accessible by phone during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours.

c. Provide and document supervision of, training for, and evaluation of PAS workers according to the requirements in the approved waiver document.

d. Provide on-site (clients' place of residence) supervision of the PAS worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances of the PAS worker.

e. Observe each PAS worker with at least one (1) assigned client at a minimum of Every six (6) months or more frequently if warranted by substandard performance of the PAS worker. This function may be carried out in conjunction with one of the 60-day supervisor visits, or at another time. Documentation of direct

supervisory visits must be maintained in the employee personnel file.

f. Assist PAS workers as necessary as they provide individual personal care services as outlined by the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

4. The following are the minimum training requirements for PAS workers. The minimum training requirement must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training. Proof of training must be recorded in the personnel file

The PAS training program should stress the physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, his/her workplace and his/her property.

NOTE: The PAS training program must be approved by the OA.

Minimum training requirements must include the following areas:

a. **Monitoring of the client, e.g.,**
. observe for signs of change in the condition
. prompt client to take medications as directed
. basic recognition of medical problems/and medical emergency
. basic first aid for emergencies

b. **Record Keeping, e.g.,**
. a daily log signed by the client or family member/responsible person and PAS Worker to document what services were provided for the client in relation to the Plan of Care and signed at least once every two weeks by the supervising nurse.

c. Basic Infection Control

d. Communication skills

e. The DSP will be responsible for providing a minimum of twelve (12) hours relevant in-service training per calendar year. (The annual in service training requirements can be done on a prorated basis.) Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided
as deemed necessary by the DSP. Any self-study training programs must be

approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed four of the twelve in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

5. **Personnel files:**
Individual records will be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

An individual client record must be maintained by the DSP. The requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PAS within three (3) working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date as stated on the Provider Contract.

2. The DSP will notify the case manager within three (3) working days of the following client changes:

   a. Client's condition has changed and the Plan of Care no longer meets client's needs or the client no longer appears to need PAS.

   b. Client dies or moves out of the service area.

   c. Client no longer wishes to participate in a program of PAS.

   d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

   e. Client becomes unemployed.

3. The DSP will maintain a recordkeeping system which establishes a client profile in support of units of PAS delivered, based on the
Service Provider Contract. The DSP will arrange a daily log reflecting the personal assistance services provided by the PAS worker for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or employer/family member/responsible person if the client is unable to sign, and the PAS worker. In the event the client is not physically able to sign and the employer/family member/responsible person is not present to sign, then the PAS worker must document the reason the log was not signed by the client or employer/family member/responsible person. The daily log must be reviewed and initialed by the Nurse Supervisor at least

once every two (2) weeks.

4. The DSP must complete the sixty (60) day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the case manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of the PAS.

5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives PAS as authorized. Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be reported in writing on Medicaid's 'WEEKLY MISSED VISIT REPORT' form to the case manager on Monday of each week. A missed visit is as follows: When the client is at his/her residence waiting for scheduled services and the services are not delivered. The provider cannot bill for missed visits.

6. Whenever two consecutive attempted visits occur, the case manager must be notified immediately. An attempted visit is when the PAS worker arrives at the residence and is unable to provide the assigned tasks because the client is not at his/her residence or refuses services. "The provider cannot bill for attempted visits."

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the operating agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.

8. The DSP will inform clients of their right to complain about the quality of PAS provided and will provide clients with information about how to register a complaint. Complaints which are made against PAS workers will be assessed for appropriateness and investigated by the DSP. All complaints which are to be investigated will be referred to the Nurse Supervisor who will take appropriate action. The DSP must maintain documentation of all complaints and follow-ups.

9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PAS to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed and the service contract form submitted prior to the provision of PAS. The DSP must maintain documentation showing that it has complied with the requirements of this section.

10. The case manager will authorize PAS by designating the amount, frequency and duration of service for clients in accordance with the client's Plan of Care which is

developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identified PAS duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the case manager to discuss the possibility of having these duties included in the Plan of Care and the Service Provider Contract. The decision to modify the duties to be performed by the PAS worker is the responsibility of the case manager, and the Plan of Care and the Service Provider Contract must be amended accordingly. This documentation will be maintained in the client records.

11. The case manager will review a client's Plan of Care within three (3) working days of the receipt of the DSP's request to modify the Plan of Care.

12. The case manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating the services. The case manager must verify Medicaid eligibility on a monthly basis.

13. Under no circumstance should any type of skilled medical service be performed by a PAS worker.

14. No payment will be made for services not listed on the Plan of Care and the Service Provider Contract.

15. The DSP will retain a client's file for at least five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The DSP Agency will inform the client/responsible party of their right to complain about the quality of PC services provided and will provide information about how to register a complaint.

   a. Complaints which are made against PAS worker will be investigated by the DSP Agency and documented in the client's file.

   b. All complaints which are to be investigated will be referred to the PAS Supervisor who will take appropriate action.

   c. The PAS Supervisor will take any action necessary and document the action taken in the client's and employee's files.

   d. The PAS Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.

2. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-service training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP agency. The DSP agency shall notify the operating agency within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The agency organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. This information shall be readily accessible to all staff. A copy of this information shall be forwarded to the operating agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP agency and to the operating agency.

3. The DSP agency must have written bylaws or equivalents which are defined as "a set of rules adopted by the DSP agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the DSP agency and shall be provided to the operating agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the DSP agency. A listing of the members of the governing body shall be made available to the operating agency upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to the operating agency prior to the signing of the initial contract with the administering agency. The DSP agency must maintain an annual operating budget which shall be made available to the operating agency upon request.

7. The DSP agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP agency shall furnish a copy of the insurance policy to the operating agency.

8. The DSP agency shall ensure that key agency staff, including the agency administrator or the Nurse Supervisor, be present during compliance review audits conducted by Medicaid, the operating agency and/or its agents.

9. The DSP agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1.___ Low income families with children as described in section 1931 of the Social Security Act.

2.__X__ SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under ə 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.__X__ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal Poverty Level (FPL)

b.____% Percent of FPL which is lower than 100%.

6.__X__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

___ A. Yes __X__ B. No

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b._X_ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)_X_ A special income level equal to:

__X__ 300% of the SSI Federal benefit (FBR)

_____ of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR 435.320, 435.322, and 435.324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b._____ % which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330.)

8._X__ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

SSI RELATED PROTECTED GROUPS DEEMED TO BE MEDICAID ELIGIBLE

These groups would include:

1. Continuous – Those individuals who are not eligible for SSI because their income exceeds the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977 ("Pickle People") (42 CFT 435.135).

2. Disabled Adult Child – An Individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child (P.L. 99-643).

Appendix C-2--Post-Eligibility

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under ∋435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (∋435.217). For individuals whose eligibility is not determined under the spousal rules (∋1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR ∋435.726 and ∋435.735 just as it does for other individuals found eligible under ∋435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under ∋1924.

REGULAR POST-ELIGIBILITY RULES--∋435.726 and ∋435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which

standard to apply.

SPOUSAL POST-ELIGIBILITY--ə1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of ə1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The ə1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in ə1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the ə1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. X The following standard included under the State plan (check one):

(1) X SSI

(2) ___ Medically needy

(3) X The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___%

(5) X Other (specify):
Individuals who would be eligible for SSI or optional state supplements as specified in 42 CFR 435.230 - if not in an institution

B. ___ The following dollar amount:
$ _____*
*If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. Is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deducting the following amounts from the waiver recipients' income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)__ SSI

(2)___ Medically needy

(3)__ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:_____%

(5)___ Other (specify):

B.___ The following dollar amount: $____*

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ∋435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the Stateэs approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

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

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

_X_ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_X_ Other (Specify):

Rehabilitation Counselor

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_X_ "Tickler" file

___ Edits in computer system

___ Component part of case management

_X_ Other (Specify): Case Managers

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid Agency in its central office

___ By the Medicaid Agency in district/local offices

_X_ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_X_ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_X_ By service providers

___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 5 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. 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.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Copies of Freedom of Choice forms will be on file at the Department of Rehabilitation Services state and area offices.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_X_ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

___ Case Manager

_X_ Other (specify):

____ Rehabilitation Counselor.

2. Copies of written plans of care will be maintained for a minimum period of 5 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid Agency central office

___ At the Medicaid Agency county/regional offices

_X_ By case managers

_X_ By the agency specified in Appendix A

___ By consumers

___ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which

these reviews will occur is:

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (specify):

.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency:

The plan of care is included in the original application package. The plan of care must be approved by the Operating Agencies Nurse Consultant. If the plan of care is of such complexity that the Quality Assurance nurses cannot approve, it will be referred to the Medicaid Agency's staff physician.

STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

10. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. **DESCRIPTION OF PROCESS**

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid Agency directly to the providers of waiver and State plan

services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

__X__ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. **BILLING AND PROCESS AND RECORDS RETENTION**

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services 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 approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

____ Yes

__X__ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

__X__ All claims are processed through an approved MMIS.

____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 5 years.

c. **PAYMENT ARRANGEMENTS**

1. Check all that apply:

__X__ The Medicaid Agency will make payments directly to providers of waiver services.

__X__ The Medicaid Agency will pay providers through the same fiscal agent used in he rest of the Medicaid program.

____ The Medicaid Agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

__X__ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

Waiver claims from these providers will be submitted to the same Medicaid Fiscal Agent used by the rest of the Medicaid programs using unique provider numbers and service indicators for tracking. Adjudication of these waiver claims will be made by the Medicaid Fiscal Agent used by the rest of the Medicaid programs.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid Agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1

COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there

is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
3	11,019	4,216	33,479	1,898
4	11,632	4,397	34,919	1,980
5	12,162	4,586	36,420	2,065

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	660
2	660
3	630
4	630
5	630

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NF

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2

FACTOR D
LOC: NF

Demonstration of Factor D estimates:

Waiver Year 1___ 2___ 3___ 4___ 5

Waiver Service Column A	#Unduplicated Recipients (Users) Column B	Avg. # Annual Units Per User Column C	Average Unit Cost Column D	Total Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

GRAND TOTAL (SUM OF COLUMN E):

AVERAGE LENGTH OF STAY: **N/A**

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_X_ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State 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.

APPENDIX G-5

FACTOR D'
LOC: NF

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

FACTOR D' (cont.)
LOC: NF

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2007-2008 with a 4.3 percent inflation factor applied to Years Four and Five remaining in the waiver period. Also, the number of recipients were adjusted upward based on more current usage information.

APPENDIX G-6

FACTOR G
LOC: NF

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for years ____of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

_X_ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2007-2008 with a 4.3 percent inflation factor applied to Years Four and Five remaining in the waiver period. Also, the number of recipients were adjusted upward based on more current usage information.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'
LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

> The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

DATE: November 2008

LOC: NF

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2007-2008 with a 4.3 percent inflation factor applied to Years Four and Five remaining in the waiver period. Also, the number of recipients were adjusted upward based on more current usage information.

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DEMONSTRATION OF COST NEUTRALITY
LOC: NF

YEAR 3

FACTOR D:	11,020		FACTOR G:	33,479
FACTOR D':	4,216		FACTOR G':	1,898
TOTAL:	15,236	≤	TOTAL:	35,377

YEAR 4

FACTOR D:	11,632		FACTOR G:	34,919
FACTOR D':	4,397		FACTOR G':	1,980
TOTAL:	16,029	≤	TOTAL:	36,899

YEAR 5

FACTOR D:	12,162		FACTOR G:	36,420
FACTOR D':	4,586		FACTOR G':	2,065
TOTAL:	16,748	≤	TOTAL:	38,485

DATE: November 2008

Exhibit B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

MICHELE HADDAD,

Plaintiff,

vs. Case No. 3:10-cv-414-J-99MMH-TEM

THOMAS ARNOLD, in his official capacity as Secretary, Florida Agency for Health Care Administration, and

DR. ANNA VIAMONTE ROSS, in her official capacity as Secretary, Florida Department of Health,

Defendants.

_____/

OPINION

THIS CAUSE came before the Court on Plaintiff Michele Haddad's[1] Motion for Preliminary Injunction, Memorandum in Support Thereof, and Expedited Hearing (Doc. No. 2; Motion),[2] filed on May 13, 2010. Plaintiff is suing Defendants, under 42 U.S.C. § 12133 and 29 U.S.C. § 794(a), alleging that they are discriminating against her on the basis of her disability in violation of the Americans with Disabilities Act (the "ADA") and the Rehabilitation

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1 Plaintiff is also involved in the related case of Jones v. Arnold, 3:09-cv-1170-J-34JRK, as a member of a putative class sought to be certified. See May 7, 2010 Order (3:09-cv-1170-J-34JRK Doc. No. 62) at 1. She initially filed a motion for preliminary injunction in the Jones case, but the Court denied that motion without prejudice because, as an unnamed class member in an uncertified class, Plaintiff was not yet a party to the action and lacked standing to seek preliminary injunctive relief therein. See id. at 1-3. Subsequently, Plaintiff filed the present action and the instant motion in her own name.

2 Attached to the Motion are Plaintiff Michele Haddad's Declaration in Support of her Motion for a Preliminary Injunction (Doc. No. 2-1; Haddad Dec.), the Declaration of Jeffery S. Johns, M.D. (Doc. No. 2-2; Johns Dec.), and the Affidavit of Kristen Russell (Doc. No. 2-3; Russell Aff. I), which was originally filed in the related Jones case.

Act (the "Rehab Act"). See Complaint (Doc. No. 1) at 1, 11-13. In the Motion, Plaintiff requested that the Court enjoin Defendants from denying her Medicaid in-home services in order to prevent her from being forced into unnecessary institutionalization in a nursing home. See Motion at 1.

I. PROCEDURAL HISTORY

Upon review of the Motion, the Court entered an order taking the Motion under advisement and directing Plaintiff to serve the Motion and supporting materials on Defendants. See May 13, 2010 Order (Doc. No. 4) at 1. While Plaintiff was complying with the Court's order, the United States filed a motion seeking leave to submit a brief in this action, see United States' Motion for Leave to Appear Specially (Doc. No. 6) at 1, and the Court granted that request, see May 21, 2010 Order at 1-2. As such, the United States filed its brief on May 24, 2010.[3] See Statement of Interest of the United States of America (Doc. No. 10; Statement of Interest).

Once Plaintiff accomplished service of process,[4] the Court entered another order scheduling a hearing on the Motion for June 7, 2010, and set an expedited briefing schedule due to the urgency of this matter. See May 25, 2010 Order (Doc. No. 13) at 1-2. In the May

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[3] Attached to the Statement of Interest are the following: an additional copy of the Russell Affidavit I (Doc. No. 10-1 at 5); a letter dated February 23, 2010 (Doc. No. 10-1 at 7-9; February 23, 2010 Letter); Defendants' Response and Memorandum of Law in Opposition to Michele Haddad's Motion for Preliminary Injunction (Doc. No. 10-1 at 11-29), originally filed in the Jones case; Initial Brief from Holly Benson, in her Official Capacity as Secretary, Florida Agency for Health Care Administration, and Douglas Beach, in his Official Capacity as Secretary, Florida Department of Elder Affairs (Doc. No. 10-1 at 31-88; Benson Brief), from the Eleventh Circuit Court of Appeals action, Benson v. Long, Case No.: 08-16261AA; January 25, 2010 Memorandum and Order Doc. No. 38 (Doc. No. 10-1 at 90-98; Benjamin Order), from the United States District Court for the Middle District of Pennsylvania action, Benjamin v. Dep't of Pub. Welfare, Commonwealth of Pa., 09-cv-1182; and a copy of Olmstead v. L.C. ex rel Zimring, 527 U.S. 581 (1999).

[4] See Returns of Service (Doc. Nos. 11 and 12) filed May 25, 2010.

25, 2010 Order, the Court directed Defendants to respond to the Motion by May 28, 2010, and permitted Plaintiff to submit a reply brief on or before June 2, 2010. See id. at 2-3. However, on May 27, 2010, Defendants filed an emergency motion requesting an extension of time in which to file their response. See Emergency Motion for Extension of Time (Doc. No 20; Emergency Motion) at 1-2. That same day, the Court held a telephonic hearing on the Emergency Motion. See May 27, 2010 Order (Doc. No. 21) at 1. During the hearing, Plaintiff's counsel advised that Plaintiff was, at that time, hospitalized due to medical complications unrelated to the alleged denial of services that are the subject of this action. Although counsel did not know when she would be medically able to be discharged, he indicated that Plaintiff was in limbo and would be unable to go home without the provision of the services at issue in the instant litigation. After hearing from the parties, the Court granted Defendants' requested extension and continued the hearing on the Motion until June 15, 2010. See Clerk's Minutes (Doc. No. 22) at 1. However, in light of Plaintiff's circumstances, the Court directed Plaintiff's counsel to immediately file a notice if Plaintiff was medically able to be released from the hospital, but not able to do so because of the unavailability of in-home health care services. In accordance with the Court's directives from the May 27, 2010 hearing, the parties timely filed their responsive memoranda, see Defendants' Response and Memorandum of Law in Opposition to Plaintiff's Motion for Preliminary Injunction (Doc. No. 27; Response); Plaintiff Michele Haddad's Response to

Defendants' Memorandum in Opposition to the Preliminary Injunction (Doc. No. 29; Reply), which are supported by various documents.[5]

The Court held a hearing on the Motion on June 15, 2010. See Clerk's Minutes (Doc. No. 39; Preliminary Injunction Hearing). At the beginning of the hearing, Plaintiff's counsel advised that Plaintiff's medical condition was improving. Indeed, Plaintiff was able to leave the hospital for a period of time to attend a portion of the hearing in person. Her counsel also advised the Court that he had spoken to Plaintiff's social worker who indicated that Plaintiff was expected to be discharged from the hospital in two to three weeks. At the conclusion of the hearing, after again confirming that Plaintiff was expected to remain hospitalized for reasons unrelated to the allegations in this action for an additional period of two to three weeks, the Court requested additional briefing from the parties on one legal issue. The parties have filed those memoranda. See Plaintiff Michele Haddad's

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[5] The Response is supported by the following: the Affidavit of Elizabeth Y. Kidder in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 24-1; Kidder Aff.); a draft copy of the Florida Nursing Home Transition Plan (Doc. No. 24-2; Transition Plan); a copy of the Settlement Agreement from Long v. Benson, 4:08cv26-RH/WCS in the United States District Court for the Northern District of Florida (Doc. No. 24-3; Long Settlement); the Affidavit of Kristen Russell in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 25-1; Russell Aff. II); the Affidavit of Susan Michele Hudson in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 26-1; Hudson Aff.); and another copy of the Russell Affidavit I (Doc. No. 27-1).

The Reply is accompanied by copies of the following: SSI-Related Programs Fact Sheets January 2010 (Doc. No. 29-1; Fact Sheets); Appendix C-Eligibility and Post-Eligibility Medicaid Eligibility Groups Served (Doc. No. 29-2; Medicaid Eligibility); Appendix B-4: Medicaid Eligibility Groups Served in the Waiver (Doc. No. 29-3; Waiver Eligibility); AARP Across the States Profiles of Long-Term Care and Independent Living (Doc. No. 29-4; AARP Profile); Florida Medicaid Nursing Homes January, 2010 Rate Semester Initial Per Diems (Doc. No. 29-5; Per Diem); a series of documents related to Defendants' October 2007 amendment of Florida's Home- and Community-Based Waiver for Individuals (aged 18 and older) with Traumatic Brain or Spinal Cord Injuries (Doc. No. 29-6; Waiver Amendment); Home and Community Based Service Waivers and Long Term Care (Doc. No. 29-7; Waiver List); Kaiser Commission on Medicaid and the Uninsured November 2009 (Doc. No. 29-8; Kaiser Report); Spinal Cord Injury in Florida, a Needs and Resources Assessment (Doc. No. 29-9; Assessment); and a letter dated January 8, 2010 (Doc. No. 29-10; January 8, 2010 Letter).

Memorandum in Response to the Court's Request Regarding Preliminary Injunction Standards (Doc. No. 41; Plaintiff's Memorandum); Defendants' Memorandum of Law on the Standard for Injunctive Relief (Doc. No. 43-1; Defendants' Memorandum); United States' Memorandum of Law Regarding the Preliminary Injunction Standard (Doc. No. 44; United States' Memorandum).

In addition to filing Plaintiff's Memorandum as directed on June 21, 2010, Plaintiff's counsel filed a notice indicating that he had "just received notice that Brooks Rehabilitation Hospital plans to discharge Michele Haddad on Thursday, June 24, 2010." See Notice of Status Regarding Michele Haddad (Doc. No. 40; Plaintiff's Notice of Status). By the time the Court reviewed Plaintiff's Notice of Status, having had the benefit of the parties' briefing and the arguments presented at the hearing, the Court had determined that preliminary injunctive relief was warranted and was in the process of preparing a written opinion and order which would grant Plaintiff relief and set forth the Court's reasons for doing so. However, upon review of Plaintiff's Notice of Status, the Court determined that the urgency of the circumstances required the issuance of an order resolving the Motion without a delay solely necessary to complete the preparation of a written opinion. Thus, the Court granted the Motion with the intention of providing an opinion setting forth its reasoning at a later date. See June 23, 2010 Order (Doc. No. 46) at 8. The Court fulfills that intention here.

II. FACTUAL BACKGROUND[6]

Plaintiff is a forty-nine-year-old resident of Florida. See Haddad Dec. at 1. On September 7, 2007, when she was forty-seven, Plaintiff was in a motorcycle accident caused by an intoxicated driver. See id. As a result of the accident, Plaintiff is paralyzed from the chest down and has a diagnosis of quadriplegia, with a spinal injury at the c6-c7 vertebrae. See Johns Dec. at 3; see also Haddad Dec. at 2. Plaintiff is mentally alert and fully aware of her surroundings, but she has minimal manual dexterity. See Johns Dec. at 4; see also Haddad Dec. at 3. Her right hand remains closed, and her left hand remains open. See Johns Dec. at 4; Haddad Dec. at 3. However, she has some limited ability to use her arms. See Johns Dec. at 4. After her accident, Plaintiff required a tracheotomy, which has been removed, but Plaintiff cannot speak and breathe at the same time. See id. Additionally, she is required to take various medications, and is at risk for injury and infection due to her catheterization. See id. Plaintiff uses a motorized wheelchair for mobility, and resides in a wheelchair-accessible home with a roll-in shower. See id.; Haddad Dec. at 2-3. Nevertheless, Plaintiff is completely dependent on others to help her perform most of her activities of daily living, including transferring from her bed to her wheelchair, dressing, bathing and showering, toileting, bladder management, assistance with bowel movements, including digital stimulation, and shopping for, preparing, and eating food. See Johns Dec.

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[6] The Court notes that, as the Motion was one for preliminary injunctive relief and necessarily before the Court on an expedited schedule, the factual record contained herein may not be completely developed. Therefore, the following facts and conclusions of law do not necessarily reflect what may be established on a record more fully developed following trial on these issues. Accordingly, the determinations in this Order are expressly limited to the record before the Court at the time of the Preliminary Injunction Hearing and do not indicate or limit the ultimate outcome of the issues presented in this matter.

at 4; see also Haddad Dec. at 3. She requires ten to twelve hours a day of in-home assistance to remain in the community.[7] See Johns Dec. at 5.

Plaintiff's rehabilitation is ongoing, and she uses the out-patient equipment and facilities at Brooks Rehabilitation Hospital ("Brooks") in Jacksonville, Florida, where she was a patient from November 2007 to January 2008, after her accident. See Johns Dec. at 3-4. Despite her dependence on the care from others, Plaintiff has maintained an active life in the community. See Haddad Dec. at 4; see also Johns Dec. at 5. She attends church, goes to the movies, visits friends, goes shopping, and exercises at the Brooks gymnasium. See Haddad Dec. at 4; see also Johns Dec. at 5. At the telephonic hearing on May 27, 2010, Plaintiff's counsel represented that Plaintiff had experienced medical complications requiring another tracheotomy and had been hospitalized at Brooks where she would remain for an unknown length of time. On June 21, 2010, Plaintiff's counsel notified the Court that Plaintiff was scheduled to be discharged from Brooks on June 24, 2010. See Plaintiff's Notice of Status at 1.

After Plaintiff's initial discharge from Brooks in January 2008, her husband was her primary care giver. See Haddad Dec. at 3; see also Johns Dec. at 5. In November 2009, Plaintiff and her husband divorced, yet he continued to provide Plaintiff's care until he moved out of their home in March 2010. See Haddad Dec. at 3; Johns Dec. at 5. After that time, one of Plaintiff's adult sons, who was living in Miami, Florida and had recently graduated

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[7] In the Complaint, which is not verified, Plaintiff asserts that she would require "about seven hours a day for all her activities of daily living." See Complaint at 5. However, Plaintiff's physician's declaration indicates that, in his medical opinion, Plaintiff "requires about 10-12 hours a day of in-home assistance in order to meet her needs." See Johns Dec. at 5. Likewise, in her declaration verifying the Motion, Plaintiff indicates that Defendants offered her 10 hours a day of services in the community if she would move into a nursing home. See Haddad Dec. at 3-4.

from college, temporarily moved back home in order to provide Plaintiff the care she needed to remain in the community. See Haddad Dec. at 3; Johns Dec. at 5. From that time until Plaintiff's hospitalization, her son became responsible for all of the tasks Plaintiff's husband had performed, including very personal care, such as hygiene and administering Plaintiff's bowel program. See Haddad Dec. at 3-4; see also Johns Dec. at 5. Plaintiff's son retumed to care for Plaintiff because of her exigent circumstances, but would be unable to provide these services to Plaintiff indefinitely. See Haddad Dec. at 4. Indeed, he intended to return to his responsibilities in Miami. See id.; Johns Dec. at 5. Upon such occurrence, absent other assistance, Plaintiff would be forced to leave the community and enter a nursing home in order to receive the care she requires. See Haddad Dec. at 4-5; Johns Dec. at 5.

Defendants are responsible for administering Florida's in-home services waiver programs, see Kidder Aff. at 1; Hudson Aff. at 1; Russell Aff. II at 1, including the Traumatic Brain Injury/Spinal Cord Injury Waiver ("TBI/SCI Waiver") program implemented in 1999, see Kidder Aff. at 2; Hudson Aff. at 1-3. Through this program, the state delivers in-home services, such as home health care and related services, to Medicaid eligible persons with traumatic brain or spinal cord injuries so that they can remain in the community. See Russell Aff. II at 1-2. The TBI/SCI Waiver program grew from a monthly caseload of 245 persons and yearly expenditures of $5,874,815 in fiscal year 2005 to 2006, to 309 persons and $10,066,381 in 2008 to 2009. See Hudson Aff. at 3. Defendants have various other waiver programs that deliver services to persons with other physical and mental disabilities. See id. at 1-3; Kidder Aff. at 2. These programs have increased in size and scope over the course of their existence. See Hudson Aff. at 1-3. In fiscal year 2008 to 2009, the average

monthly caseload of Medicaid recipients in nursing homes was approximately 50,000, and the average monthly caseload in in-home services waiver programs was approximately 61,000. See id. at 4.

In November 2007, while Plaintiff was still at Brooks, she applied to receive services under Defendants' TBI/SCI Waiver. See Haddad Dec. at 2-3; see also Johns Dec. at 5. However, Plaintiff has not received any TBI/SCI Waiver services despite having been on the waiting list for approximately two-and-a-half years. See Haddad Dec. at 3-5. In a letter dated January 8, 2010, Defendants acknowledged that Plaintiff was on a waiting list to receive in-home services, but explained:

> [p]resently, the Department of Children and Families does not have funds available (or available openings) to serve additional individuals through these programs. . . . Placement on the waiting list does not ensure future eligibility. Funding is very limited in these programs, and the amount of funding allocated to these programs has not been increased in many years. Unfortunately, moving individuals off the waiting list into these programs does not occur frequently, therefore, we encourage you to continue seeking services from other programs.

January 8, 2010 Letter at 1.

Plaintiff's income is limited to her Social Security Disability Insurance, and she is eligible for, and receives, Medicare and Medicaid. See id. at 4. With her other sources of assistance withdrawing, Plaintiff faced the risk of institutionalization without in-home services through Defendants' TBI/SCI Waiver.[8] See id. at 5; Johns Dec. at 5. Accordingly, Plaintiff

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[8] Plaintiff argues that an additional potential source of assistance is Defendants' personal care services waiver, but contends that this program is only available to individuals residing in nursing homes. See Motion at 5-6, 19 n.5; Transcript of June 15, 2010 Hearing (Doc No. 47; Tr.) at 8. However, at the hearing, Defendants argued that there is no personal care services program. See Tr. at 33-35, 100-02. Instead, services of a personal nature, such as those Plaintiff requires, which are rendered to individuals in nursing homes are incidental to the nursing home placement. See id. They are not the (continued...)

contacted Defendants in early March 2010, to notify them of the change in her circumstances, and that she desperately required in-home services. See Haddad Dec. at 4. In late April 2010, Defendants informed Plaintiff that there were no funds for in-home services, but if she would move into a nursing home, after sixty days in the nursing home, she would be eligible to receive ten hours a day of in-home services through the Florida Nursing Home Transition Plan (the "Transition Plan"). See id.; Russell Aff. I at 2; Tr. at 109-15; see also Transition Plan at 1-12; Long Settlement at 1-13. However, Plaintiff does not wish to enter a nursing home; she wishes to receive the in-home services for which she is medically and financially eligible and to remain in the community, where she leads an active life. See Haddad Dec. at 3-4. Additionally, Plaintiff's physician opines that, even if she meets the criteria for nursing home care, Plaintiff will quickly become depressed and her health will most likely deteriorate if she is placed in a nursing home. See Johns Dec. at 5.

Plaintiff is eligible for the TBI/SCI Waiver, see Kidder Aff, at 3; Medicaid Eligibility at 1-2; Waiver Eligibility at 1-2; Fact Sheets at 4-5, and would benefit from the program, see Johns Dec. at 5, however, Defendants have represented that there are no funded slots available in the program at this time, see January 8, 2010 Letter at 1; Russell Aff. I at 2; Haddad Dec. at 4. Priority of placement on the TBI/SCI Waiver waiting list is based on the probability, given the individual's level of community support and severity of needs, that, but for the TBI/SCI Waiver, the non-institutionalized individual will be institutionalized or the

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[8](...continued)
subject of an independent waiver or funding source. See id. Plaintiff focused her argument on the waiver program and provided little argument regarding her entitlement to in-home services based on the fact that such services would otherwise be incidental to institutionalization. As such, the Court's ruling addresses only Plaintiff's primary argument at this time.

institutionalized individual will not be deinstitutionalized. See Russell Aff. II at 2. At the Preliminary Injunction Hearing, defense counsel was unsure of Plaintiff's exact position on the waiting list, but represented to the Court that she was not in the top forty-five spots. See Tr. at 51-52. Defendants did not know the average wait time for individuals on the waiting list or the average turnover. See id. at 54, 57, 102-03. However, Defendants explained that, because movement on the waiting list is based on an individual's needs, rather than time spent on the waiting list, the wait time can vary greatly from person to person. See id. at 102-03. If a person's needs change, they can request reassessment which can change their position on the waiting list. See id. at 102-03, 115. Nevertheless, despite Plaintiff's contact with Defendants in March 2010, advising them of her change in circumstances, Plaintiff has not been reassessed since January 2010. See id. at 115-16.

Although Plaintiff has been on the waiting list for waiver services since at least early 2008, and Defendants have represented to Plaintiff that the TBI/SCI Waiver program is full, the data from 2008 to 2009 may conflict with this representation. The TBI/SCI Waiver has been approved for 375 persons for the period beginning July 1, 2007, through June 30, 2012. See Waiver Amendment at 1. According to the Waiver List, which summarizes information regarding the utilization and cost of the state's various waiver programs, as of November 1, 2008, the TBI/SCI Waiver had an enrollment of only 343 persons and a waiting list of 554 persons. See Waiver List at 2. Additionally, the Hudson Affidavit represents that, at the end of fiscal year 2008 to 2009, enrollment in the TBI/SCI Waiver was 309 persons. See Hudson Aff. at 3. Thus, it is unclear whether all 375 funded slots in the TBI/SCI Waiver Program are fully utilized.

Even if the program is full, Defendants readily acknowledge that they could expand the number of slots in the program before 2012, see id. at 59-60, but that would only guarantee money from the federal government. Defendants would still need to provide Florida's portion of the funding, as well as the expanded provider network necessary to support such an expansion, see id. at 65-66. However, Defendants provided no evidence as to the cost or impact of such an expansion on other programs or its ability to provide adequate services to the state's disabled population. Nevertheless, Defendants do assert that placing Plaintiff into the program would violate the TBI/SCI Waiver rules because Plaintiff is not next on the waiting list, and that if Defendants were forced to place Plaintiff in the TBI/SCI Waiver, they would have to reduce services that others in the program are currently receiving. See Russell Aff. I at 2; see also Tr. at 49-50, 66-67.

Nursing home care is a mandatory service under Medicaid, and if Plaintiff is required to enter a nursing facility, Defendants would have to pay for such care irrespective of budgetary constraints. See Tr. at 111. Defendants admit that, "[i]n most cases, when a Medicaid recipient is diverted or transitioned from a nursing facility to an [in-home services] waiver program, costs to Medicaid for providing care to that individual are reduced." Hudson Aff. at 3. Indeed, for budgeting purposes, Defendants assume a two-to-one savings for those diverted from nursing homes. See id. at 3-4. However, because of Defendants' budget structure, Defendants would require Plaintiff to enter a nursing home, where funding comes from the state's nursing home line item which the state is required to pay. See Tr. at 111. Then, after at least sixty consecutive days in a nursing facility, Plaintiff would be

eligible for the in-home services she requires from the TBI/SCI Waiver through the Transition Plan. See Kidder Aff. at 2; Tr. at 110-14.

The Transition Plan is independently funded by the Florida legislature through the nursing home line item, see Kidder Aff. at 2; Tr. at 112, and was implemented to give Defendants a funding source to deinstitutionalize individuals who are qualified for in-home services but are languishing in nursing homes because of full waiver programs, see Tr. at 110-11. Essentially, the Transition Plan gives Defendants' budget flexibility. See id. at 111. The sixty-day requirement was implemented to avoid gamesmanship, such as individuals entering nursing facilities for a day and then jumping out immediately into a waiver program, see id. at 112-14, and Defendants contend that the requirement assures that an individual would legitimately, but for in-home services, enter a nursing home and be institutionalized, see id. at 104-06 ("Well, if somebody is going to spend 60 days in a nursing home, that makes it much more likely that they would have had to, without these waiver services, go into a nursing home. It's essentially an assessment of need."). Additionally, Defendants explain that the policy reflects Florida's focus on deinstitutionalization as a priority over diversion. See id. at 106-07. Notably, however, Defendants do not assure that Plaintiff will be transitioned into the TBI/SCI Waiver immediately after sixty consecutive days in a nursing facility. See id. at 19, 73-75. Instead, Defendants state that Plaintiff would have to be institutionalized for "at least" sixty days, but then would have to be assessed and be determined to be safe for community placement. By this action, Plaintiff seeks injunctive relief requiring Defendants to provide her with in-home services without first subjecting herself to unnecessary institutionalization.

III. DEFENDANTS' "STANDING" CHALLENGE

As an initial matter, Defendants assert that Plaintiff lacks standing to pursue this action because she has not been discriminated against "by reason of . . . disability" and because any claims she has are precluded by a settlement reached in the case of Dubois v. Levine, Case No. 4:03-CV-107-SPM from the United States District Court for the Northern District of Florida. See Defendants' Motion to Dismiss Complaint (Doc. No. 32; Motion to Dismiss).[9] Although Defendants did not raise these arguments as a challenge to Plaintiff's standing to sue in response to the Motion, they did present them in their Motion to Dismiss and during the Preliminary Injunction Hearing. While Defendants suggest that their arguments present a challenge to Plaintiff's standing to pursue this action, that contention is simply without merit.

Standing is a jurisdictional requirement, and the party invoking federal jurisdiction has the burden of establishing it. See Lujan v. Defenders of Wildlife, 504 U.S. 555, 561 (1992). In order to establish standing under Article III of the United States Constitution, a plaintiff must "allege such a personal stake in the outcome of the controversy as to warrant [her] invocation of federal-court jurisdiction and to justify exercise of the court's remedial powers on [her] behalf." Watts v. Boyd Properties, 758 F. 2d 1482, 1484 (11th Cir. 1985) (quoting Warth v. Seldin, 422 U.S. 490, 499-500 (1975)). Specifically, a plaintiff must prove three elements in order to establish standing: (1) that he or she has suffered an "injury-in-fact," (2) that there is a "causal connection between the asserted injury-in-fact and the challenged

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[9] Plaintiff has responded to the Motion to Dismiss. See Plaintiff Michele Haddad's Memorandum of Law in Opposition to Defendants' Motion to Dismiss Complaint (Doc. No. 35; Response to Motion to Dismiss).

action of the defendant," and (3) that a favorable decision by the court will redress the injury. See Shotz v. Cates, 256 F. 3d 1077, 1081 (11th Cir. 2001) (internal citations omitted). "These requirements are the 'irreducible minimum' required by the Constitution for a plaintiff to proceed in federal court." Id. at 1081 (quoting Northeastern Fla. Chapter of Associated Gen. Contractors of America v. City of Jacksonville, 508 U.S. 656, 664 (1993)) (internal citations omitted). Additionally, in an action for injunctive relief, a plaintiff has standing only if the plaintiff establishes "a real and immediate–as opposed to a merely conjectural or hypothetical–threat of future injury." See Wooden v. Board of Regents of University System of Georgia, 247 F. 3d 1262, 1284 (11th Cir. 2001). A complaint that includes "only past incidents of discrimination" is insufficient to allege a real and immediate threat of future injury. See Shotz, 256 F. 3d at 1081.

Defendants do not attempt to contest that Plaintiff can satisfy each of these requirements. Instead, they appear to present a challenge to Plaintiff's ability to state a claim for relief under the ADA, as well as a potential defense - that Plaintiff's claims are barred by issue preclusion - or collateral estoppel. See Motion to Dismiss at 4; see Cope v. Bankamerica Hous. Serv., Inc., No. Civ.A. 99-D-653-N., 2000 WL 1639590, at *4 (M.D. Ala. Oct. 10, 2000). Upon review of Plaintiff's claims, the Court is fully satisfied that she has alleged an injury in fact, which is purportedly caused by the Defendants' actions, and for which a favorable decision by the Court would provide redress. Moreover, Plaintiff alleges a real and immediate threat of future injury. Thus, the Court determines that Plaintiff has standing to pursue the claims raised in this action. Moreover, neither of the challenges raised by Defendants in their "standing" discussion is actually a challenge to the Court's

subject matter jurisdiction. Thus, the Court will consider these arguments as challenges to Plaintiff's ability to succeed on the merits of her claims.

IV. STANDARD FOR RELIEF

A party seeking preliminary injunctive relief must establish that "(1) it has a substantial likelihood of success on the merits, (2) the movant will suffer irreparable injury unless the injunction is issued, (3) the threatened injury to the movant outweighs the possible injury that the injunction may cause the opposing party, and (4) if issued, the injunction would not disserve the public interest" before the district court may grant such relief. Horton v. St. Augustine, 272 F.3d 1318, 1326 (11th Cir. 2001) (citing Siegel v. LePore, 234 F.3d 1163, 1176 (11th Cir. 2000)); see also Int'l Cosmetics Exch. v. Gapardis Health & Beauty, Inc., 303 F.3d 1242, 1246 (11th Cir. 2002) (citing Levi Strauss & Co. v. Sunrise Int'l Trading Inc., 51 F.3d 982, 985 (11th Cir. 1995)). Additionally, "[i]t is well established in this circuit that a preliminary injunction is an extraordinary and drastic remedy not to be granted unless the movant clearly established the burden of persuasion as to all four elements." Siegel, 234 F.3d at 1176 (internal quotations and alterations omitted).

A typical preliminary injunction is prohibitive in nature and seeks simply to maintain the status quo pending a resolution of the merits of the case. See Mercedes-Benz U.S. Int'l, Inc. v. Cobasys, LLC, 605 F. Supp. 2d 1189, 1196 (N.D. Ala. 2009). When a preliminary injunction is sought to force another party to act, rather than simply to maintain the status quo, it becomes a "mandatory or affirmative injunction" and the burden on the moving party increases. Exhibitors Poster Exch. v. Nat'l Screen Serv. Corp., 441 F.2d 560, 561 (5th Cir. 1971). Indeed, a mandatory injunction "'should not be granted except in rare instances in

which the facts and law are clearly in favor of the moving party.'" Id. (quoting Miami Beach Fed. Sav. & Loan Ass'n v. Callander, 256 F.2d 410, 415 (5th Cir. 1958)); see also Martinez v. Mathews, 544 F.2d 1233, 1243 (5th Cir. 1976)[10] ("Mandatory preliminary relief, which goes well beyond simply maintaining the status quo pendente lite, is particularly disfavored, and should not be issued unless the facts and law clearly favor the moving party."). Accordingly, a plaintiff seeking such relief bears a heightened burden of demonstrating entitlement to preliminary injunctive relief. See Verizon Wireless Pers. Commc'n LP v. City of Jacksonville, Fla., 670 F. Supp. 2d 1330, 1346 (M.D. Fla. 2009) (quoting the Southern District of New York, "Where a mandatory injunction is sought, 'courts apply a heightened standard of review; plaintiff must make a clear showing of entitlement to the relief sought or demonstrate that extreme or serious damage would result absent the relief.'"); Mercedes-Benz, 605 F. Supp. 2d at 1196; OM Group, Inc. v. Mooney, No. 2:05-cv-546-FtM-33SPC, 2006 WL 68791, at *8-9 (M.D. Fla. Jan. 11, 2006).

Here, the parties disagree as to the nature of the relief sought. Plaintiff contends that because she merely seeks to prohibit unlawful discrimination, the injunctive relief she requests is prohibitive in nature and does not seek to change the status quo. However, Defendants argue that because Plaintiff is not currently receiving in-home health care services from Defendants, and requests that this Court order Defendants to provide her with such services, she seeks to change the status quo by requiring them to act. Because the Court determined that Plaintiff satisfied the heightened burden of demonstrating her

[10] In Bonner v. City of Prichard, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), the Eleventh Circuit adopted as binding precedent all the decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981.

entitlement to mandatory preliminary injunctive relief, the Court did not resolve the parties' dispute as to the applicable standard.

V. DISCUSSION

A. SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[11] 42 U.S.C. § 12132. In the decision of Olmstead v. L.C. ex rel Zimring, 527 U.S. 581 (1999), the Supreme Court considered the application of this anti-discrimination provision in a rather unique context:

> we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions.

Id. at 587. The Court answered this question with a "qualified yes." See id. In doing so, the Court held that the unjustified institutional isolation of persons with disabilities is a form of discrimination by reason of disability. See id. at 597, 600-01. The Court explained:

> 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

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[11] Plaintiff's Rehab Act claim is essentially the same as her ADA claim, and discrimination claims of this kind are analyzed similarly under the two acts. See Allmond v. Akal Sec., Inc., 558 F.3d 1312, 1316 n.3 (11th Cir. 2009) ("Because the same standards govern discrimination claims under the Rehabilitation Act and the ADA, we discuss those claims together and rely on cases construing those statutes interchangeably."). Accordingly, the Court will refer primarily to the ADA for the sake of brevity.

> treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Id. at 600-01 (internal citations omitted). To avoid the discrimination inherent in the unjustified isolation of disabled persons, public entities are required to make reasonable modifications to policies, practices, and procedures for services they elect to provide. Nevertheless, the Olmstead Court recognized that a state's responsibility, once it determines to provide community-based treatment, is not without limits. See id. at 603.[12] Rather, the regulations implementing the ADA require only "reasonable modifications" and permit a state to refuse alterations to programs that will result in a fundamental alteration of the program or service. See id.

In considering whether a proposed modification is a reasonable modification, which would be required, or a fundamental alteration, which would not, the Olmstead Court determined that a simple comparison showing that a community placement costs less than an institutional placement is not sufficient to establish reasonableness because it overlooks other costs that the state may not be able to avoid. See id. at 604. The Court explained,

> Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

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[12] "'[W]hile "[t]he section of Justice Ginsburg's opinion discussing the state's fundamental alteration defense commanded only four votes . . . [b]ecause it relied on narrower grounds than did Justice Stevens' concurrence or Justice Kennedy's concurrence, both of which reached the same ultimate result, Justice Ginsburg's opinion controls."'" Arc of Washington State Inc. v. Braddock, 427 F.3d 615, 617 (9th Cir. 2005) (quoting Sanchez v. Johnson, 416 F.3d 1051, 1064 n.7 (9th Cir. 2005), quoting Townsend v. Quasim, 328 F.3d 511, 519 n.3 (9th Cir. 2003)).

Id. Indeed, the Court recognized that the fundamental alteration defense must be understood to allow some leeway to maintain a range of facilities and services. See id.

> If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. . . . In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.

Id. at 605-06. Thus, having considered the ADA as well as the applicable regulations, the Court concluded that the ADA requires states to provide community based treatment for persons with disabilities when: (1) the state's treatment professionals have determined that community-based services are appropriate for an individual; (2) the individual does not oppose such services; and (3) the services can be reasonably accommodated, taking into account (a) the resources available to the state, and (b) the needs of others with disabilities. See id. at 602-04, 607; Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare, 402 F.3d 374, 379-80 (3d Cir. 2005); Frederick L. v. Dep't of Pub. Welfare of the Commonwealth of Pa., 364 F.3d 487, 493 (3d Cir. 2004); Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1181 (10th Cir. 2003). When these requirements are met, states must provide services to individuals in community settings rather than in institutions. See Fisher, 335 F.3d at 1181.

Before addressing the Court's conclusion that Plaintiff has established that she has a substantial likelihood of satisfying these requirements such that Defendants should be ordered, at this stage of the proceedings, to provide her with in-home services, the Court will first discuss Defendants' general challenges to Plaintiff's ability to pursue this action.

Defendants first argue that Plaintiff cannot state a claim of discrimination under the ADA because she is not being discriminated against "by reason of such disability" here because all in-home services waiver programs discriminate by their nature, providing services solely to disabled individuals and not to non-disabled individuals. See Response at 5-6; Motion to Dismiss at 4. However, the Eleventh Circuit and the Supreme Court have squarely rejected this argument. See Olmstead, 527 U.S. at 597-601 (affirming the finding of disability-based discrimination in L.C. v. Olmstead, 138 F.3d 893, 897-901 (11th Cir. 1998)). The unjustified institutional isolation of persons with disabilities is a form of disability-based discrimination that need not be accompanied by dissimilar treatment of non-disabled persons. See id. Indeed, in rejecting this same argument by the state in Olmstead, the Court specifically stated, "Congress had a more comprehensive view of the concept of discrimination advanced in the ADA," id. at 598, than the view espoused by the state. Therefore, Defendants' argument is not well taken.

Next, Defendants assert that Plaintiff's claims are barred by the doctrine of collateral estoppel. See Motion to Dismiss at 3-5. Specifically, Defendants explain that the issues underlying Plaintiff's claims were previously adjudicated by the settlement in the Dubois litigation, see Motion to Dismiss at 3-5, which resolved the claims of a class defined as encompassing "all individuals with traumatic brain or spinal cord injuries who the state has already determined or will determine to be eligible to receive services from Florida's Medicaid Waiver Program for persons with traumatic brain and spinal cord injuries and have not yet received such services," see Settlement (Doc. No. 32-2; Dubois Settlement) at 1.

The doctrine of collateral estoppel, also referred to as issue preclusion, bars the relitigation of issues that previously have been litigated and decided. See Irvin v. United States, 335 F. App'x 821, 822-23 (11th Cir. 2009); Christo v. Padgett, 223 F.3d 1324, 1339 (11th Cir. 2000). To apply collateral estoppel, the following elements must be present: "(1) the issue at stake is identical to the one involved in the prior proceeding; (2) the issue was actually litigated in the prior proceeding; (3) the determination of the issue in the prior litigation must have been 'a critical and necessary part' of the judgment in the first action; and (4) the party against whom collateral estoppel is asserted must have had a full and fair opportunity to litigate the issue in the prior proceeding." See Christo, 223 F.3d at 1339 (quoting Pleming v. Universal-Rundle Corp., 142 F.3d 1354, 1359 (11th Cir. 1998)). The principles of collateral estoppel are generally applicable to judgments entered in class actions like Dubois. See Cope, 2000 WL 1639590, at *5. However, while Defendants have provided the Court with a copy of the Dubois Settlement which was approved by the court, this single document is insufficient to establish that the first three prerequisites for collateral estoppel have been satisfied.[13] However, even if they are satisfied, a review of the Dubois

[13] Indeed, a cursory review of the Dubois Settlement raises significant questions about the Defendants' ability to satisfy the second and third elements. Paragraph H(2) of the Dubois Settlement agreement provides "all legal representations, including agreements based on legal claims, attributable to the Defendants as set out herein are solely and exclusively for the purpose of this settlement and shall not be binding on these Defendants or Plaintiffs in any other action or proceeding. . . ." See Dubois Settlement at 11. Thus, it appears that the parties to the Dubois Settlement specifically intended that their agreement not have any prospective preclusive effect. Moreover, the Dubois Settlement affirmatively provides "this agreement is not an admission of any wrongdoing or misconduct on the part of Defendants nor is it an admission by Plaintiffs that Defendant would have prevailed in this litigation." See id. at 8. In Cope, the court found the second element of collateral estoppel lacking where the settlement agreements at issue contained provisions indicating that the settlements did not constitute admissions of fault, liability or wrongdoing or an admission that the claims were valid. In doing so, the court noted that in accepting the prior settlement agreements, the reviewing court did not actually "determine" any issues bearing on the defendant's liability. See Cope, 2000 WL 1639590, at *9-10. Therefore, the common issues had not actually been litigated. See id. Here, the parties did not present

(continued...)

Settlement establishes that Defendants cannot satisfy the fourth element. Thus, their collateral estoppel defense fails.

The Eleventh Circuit has found the "opportunity to litigate" element satisfied where a litigant was a party to the previous action, and was afforded a full and fair opportunity to address the issues in question. See Irvin, 335 F. App'x at 823; Christo, 223 F.3d at 1340. However, where a particular claim has not accrued at the time of the earlier proceeding, litigants cannot be said to have had a full and fair opportunity to litigate the issues. See In re Jennings, 378 B.R. 687, 696 (M.D. Fla. 2006) (full and fair opportunity to litigate requirement not satisfied where party had not yet been authorized to pursue a claim when the preceding adjudication occurred). Plaintiff was not a party to the Dubois litigation, nor was she a member of the class who would have had an opportunity to object to the settlement. This is so because Plaintiff did not suffer her injury until September 7, 2007, after the Dubois action was filed and even after the Dubois Settlement was signed and approved by the court. Accordingly, she had no opportunity to litigate her claims which had not yet accrued. See In re Jennings, 378 B.R. at 696.

Defendants' authorities in support of issue preclusion based on the Dubois Settlement are unavailing. In Reyn's Pasta Bella, LLC v. Visa USA, Inc., class members who were parties to the judicial proceedings were precluded from collaterally attacking a settlement agreement where they were part of the class and represented by counsel at the fairness hearing on the settlement agreement. See 442 F.3d 741, 746-47 (9th Cir. 2006). Similarly,

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[13](...continued)
argument regarding the satisfaction of these elements of collateral estoppel in any detail. Because the Court finds that the final element required for collateral estoppel is clearly lacking, it need not address these elements further.

in Carter v. Rubin, the court noted that "[c]ollateral estoppel, or issue preclusion, . . . bars 'relitigation of [an] issue in a suit on a different cause of action involving a party to the first case.'" See 14 F. Supp. 2d 22, 34 (D.D.C. 1998) (second alteration in original underline supplied). Unlike these plaintiffs, Plaintiff Haddad was not a party to the Dubois litigation.

In an effort to overcome this deficiency, Defendants assert that a strict reading of the class certified in Dubois establishes that Plaintiff is bound by that adjudication because she falls within the class definition which included "all individuals with traumatic brain or spinal cord injuries who the state has already determined or will determine to be eligible to receive services from Florida's Medicaid Waiver Program . . . and have not yet received such services." See Dubois Settlement at 1. However, Plaintiff could not have been a member of that class because, at the time the complaint was filed and the Dubois Settlement was signed and approved, she had no such injury. The language "who the state has already determined or will determine to be eligible to receive services" does not extend the class, ad infinitum, to all those for whom the state will ever make such a determination even though they had no injury at the time the Dubois Settlement was contemplated. Rather, this language plainly refers to those with such injuries at the time of the action, whether or not the state had determined their eligibility for services. Accordingly, Plaintiff's claims in this action are not barred by the Dubois Settlement.

Defendants also contend that the motion for preliminary injunction must be denied because the implementing regulations of the ADA do not create a private right of action, and therefore, Plaintiff has no claim. Defendants cite Am. Ass'n of People with Disabilities v. Harris, 605 F.3d 1124 (11th Cir. 2010) in support of this contention, but Harris is inapplicable

to the present case. In Harris, the plaintiffs filed suit against various state actors for failure to provide handicapped-accessible voting machines. See Harris, 605 F.3d at 1126-27. The district court dismissed the plaintiffs' claims under the ADA, Rehab Act, and the Florida Constitution and statutes, but permitted them to amend their complaint. See id. at 1127-28. The plaintiffs then filed a two-count amended complaint, asserting claims under the ADA and the Rehab Act. See id. at 1128. After a bench trial, the district court issued a declaratory judgment and an injunction against the Supervisor of Elections ("Supervisor") based not on a finding that he or any defendant violated the ADA or the Rehab Act, but rather based on a conclusion that the Supervisor of Elections violated the ADA's implementing regulation, 28 C.F.R. § 35.151(5), which deals with nondiscrimination on the basis of disability in state and local services. See id. at 1128-29. The Supervisor appealed the injunction, but while that appeal was pending, other circumstances rendered it moot. See id. at 1130. The district court then entered final judgment against the Supervisor in accordance with the declaratory judgment and injunction, which the Supervisor appealed. See id. at 1130-31.

In vacating the district court's judgment, the Eleventh Circuit noted that, although the amended complaint contained claims under the ADA and the Rehab Act, the judgment did not declare that the defendants had violated either of those statutes. See id. at 1131. In fact, there was no finding at all in regard to the ADA or the Rehab Act. See id. The district court's judgment was, instead, limited to finding a violation of the ADA's implementing regulation. See id. The Eleventh Circuit opined that it was unclear where the district court had found the authority to order the Supervisor to comply with the implementing regulation without first determining whether the ADA, itself, authorized such relief. See id. Indeed,

after performing such an analysis, the Eleventh Circuit held that there was no private right of action arising from the implementing regulation alone because congress placed available recourse within the ADA's express statutory right of action. See id. at 1132-35. Thus, absent a violation of the ADA, a violation of its implementing regulations would not create a private right of action and remedy. See id. at 1135-36.

Nevertheless, Harris' holding presents no bar to Plaintiff's claims because she is asserting a violation of the ADA, which does afford a private right of action. Indeed, Harris recognized that the ADA includes an express statutory right of action. See id. Moreover, the Supreme Court in Olmstead specifically found that unjustified isolation, under certain circumstances, can constitute a violation of the ADA. See 527 U.S. at 597. This is the basis of Plaintiff's action–not a violation of the ADA's integration mandate, separate from the ADA or the Rehab Act, as in Harris. Therefore, Harris presents no bar to Plaintiff's assertion of her right of action for a violation of the ADA based on unjustified isolation. See id. at 596-602; see also Crabtree v. Goetz, NO. CIV.A. 3:08-0939., 2008 WL 5330506, at *24 (M.D. Tenn. Dec. 19, 2008); Grooms v. Maram, 563 F. Supp. 2d 840, 851-854, 854 n.3 (N.D. Ill. 2008); Radaszewski v. Maram, No. 01 C 9551., 2008 WL 2097382, at *14 (N.D. Ill. Mar. 26, 2008). Defendants' arguments to the contrary simply reflect a mischaracterization of Plaintiff's claims. See Response at 5-6; Tr. at 36-38.

Alternatively, Defendants argue that Plaintiff cannot pursue her ADA claim because the Court must respect the plain language of the ADA regulations which instruct that a public entity need not provide personal care services. See Response at 6-10. Specifically, they rely on 42 C.F.R. § 35.135 which states that public entities are not required to provide

"services of a personal nature including assistance in eating, toileting, or dressing." Defendants contend that in light of this regulation, the ADA cannot be interpreted to require them to provide such services to Plaintiff. See id. at 6. However, Defendants' argument misses the mark. The ADA does not require states to provide a level of care or specific services, but once states choose to provide certain services, they must do so in a nondiscriminatory fashion. See Olmstead, 527 U.S. 581, 603 n.14; see also Fisher, 335 F.3d at 1182 (state may not amend optional programs so as to violate the ADA); cf. Rodriguez v. City of New York, 197 F.3d 611, 619 (2d Cir. 1999) (no ADA violation where plaintiffs requested service not already provided by defendant). Here, Defendants have elected to provide the services that Plaintiff requests through the TBI/SCI Waiver program. Having done so, they must provide them in accordance with the ADA's anti-discrimination mandate. Therefore, if Plaintiff is entitled to Medicaid services and is otherwise qualified for, desires, and requires TBI/SCI Waiver services in order to avoid unnecessary institutionalization, the ADA may, indeed, require Defendants to provide Plaintiff with such services if doing so would not result in a fundamental alteration of its programs.

Defendants last broad challenge to the sufficiency of Plaintiff's claims is their argument that the ADA cannot abrogate or amend the Medicaid Act to make personal care services mandatory or to require Defendants to uncap their TBI/SCI Waiver program. See Response at 14-17. Specifically, Defendants contend that "the only way that Plaintiff's claims could be sustained is if the ADA were interpreted to amend (or partially repeal) the Medicaid Act by implication, by either amending/repealing 42 U.S.C. § 1396a(a)(10)(A), which makes personal care services optional for states" or by requiring states to provide

services under waiver programs. Response at 14. Indeed, Defendants conclude, "if the ADA's prohibition of discrimination 'by reason of . . . disability' amends the Medicaid Act, then surely the HCBS waiver programs would not survive." Response at 17. This is so, they argue, because waiver programs by their nature discriminate based on disability. The Court concludes that Defendants' arguments are unavailing.

First the Court rejects Defendants' contention that the success of Plaintiff's action requires a finding that the ADA invalidates or amends the Medicaid Act by mandating the provision of personal care services which are otherwise an optional benefit. Plaintiff's claim requires no such finding. A determination that Plaintiff Haddad should be provided the services at issue to avoid imminent institutionalization does not require a finding that states are required to provide personal care services as a mandatory Medicaid benefit. Indeed, Plaintiff is not seeking an order requiring Defendants to provide particular services through a waiver program, nor does she contend that the ADA prohibits states from imposing any limit on such programs. Instead, she contends that because Defendants have chosen to provide personal care services through the TBI/SCI Waiver to persons such as herself, Defendants must administer its provision of those services in compliance with the ADA. A state that chooses to provide optional services, cannot defend against the discriminatory administration of those services simply because the state was not initially required to provide them. Indeed, Defendants have provided no authority for the proposition that a state that chooses to provide Medicaid services, even if otherwise optional, would not be required to comply with the ADA in the provision of those services, just as it would have to comply with the ADA for any other "services, programs, or activities" provided by a public entity.

The Court finds similarly unavailing Defendants' contention that Plaintiff's claim requires the Court to invalidate 42 U.S.C. § 1396n(c)(1), (9) and (10), which make waiver programs voluntary and permit states to cap the enrollment in such programs.[14] No such relief is sought in this action. Plaintiff's claim simply addresses the question of whether these Defendants, having opted to provide particular services via the mechanism of a Medicaid Waiver Program, may be required, under the ADA, to provide those same services to her if necessary to avoid imminent, unnecessary institutionalization. Defendants attempt to characterize such a finding as an invalidation of the Medicaid Act is without merit.

Having dispensed with Defendants' general challenges to Plaintiff's ability to pursue the instant cause of action, the Court turns its attention to the determination set forth in the June 23, 2010 Order that Plaintiff has clearly established that she has a substantial likelihood of prevailing on the merits of her claims. As previously noted, the Olmstead Court determined that the ADA requires states to provide community based treatment for persons with disabilities when: (1) the state's treatment professionals have determined that community-based services are appropriate for an individual; (2) the individual does not

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[14] The Department of Health & Human Services, Center for Medicaid and State Operations Olmstead Update No: 4 supports this determination:

> May a state establish a limit on the total number of people who may receive services under an [in-home services] waiver? Yes. . . . The State does not have an obligation under Medicaid law to serve more people in the [in-home services] waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the [in-home services] waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

http://www.cms.gov/smdl/downloads/smd011001a.pdf ("Olmstead Update"); Reply at 9 (emphasis in original omitted; underline supplied).

oppose such services; and (3) the services can be reasonably accommodated, taking into account (a) the resources available to the state and (b) the needs of others with disabilities. See Olmstead, 527 U.S. at 602-604, 607.

It is undisputed that Defendants are public entities. Likewise, Defendants do not dispute that Plaintiff is a "qualified individual with a disability" who could be served in the community. Additionally, Plaintiff has provided ample evidence that she will have to enter an institution in order to receive the in-home services that would allow her to remain in the community and which Defendants provide through their TBI/SCI Waiver program. Indeed, Defendants have denied Plaintiff in-home services to date unless she first enters a nursing home so that funding for her services can be obtained from the Transition Plan. Thus, there is no dispute over the first two Olmstead factors. Plaintiff is on the waiting list as a qualified individual and Defendants admit she is medically eligible for institutional and waiver program care. Not only does Plaintiff not oppose receipt of in-home services, she describes herself as desperately seeking them. The only factor in question, then, is whether Plaintiff's requested accommodation, receipt of in-home services, is a reasonable accommodation in light of Defendants' resources and their obligations to other disabled individuals.

Defendants do not dispute that providing in-home services costs less than nursing home placement. As Plaintiff is qualified, and desires, to receive in-home services, and the provision of in-home services is cost-neutral,[15] the Court turns to the question of whether Plaintiff's requested accommodation would result in a fundamental alteration of Defendant's programs. See Radaszewski v. Maram, 383 F.3d 599, 614 (7th Cir. 2004) (reversing

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[15] Indeed, in-home services are cost-saving rather than merely cost-neutral.

judgment in defendant's favor and remanding for consideration of whether the requested relief "is unreasonable or would require a fundamental alteration of the State's programs and services for similarly situated disabled persons."); Townsend v. Quasim, 328 F.3d 511, 519-20 (9th Cir. 2003) (reversing judgment and remanding for consideration of whether the modification requested would fundamentally alter the nature of services provided by the state); see also Fisher, 335 F.3d at 1180-81; Messier v. Southbury Training Sch., 562 F. Supp. 2d 294, 323 (D. Conn. 2008).

Defendants argue that Plaintiff's requested relief would constitute a fundamental alteration of its program because providing services to Plaintiff would cost more than Plaintiff's cost analysis indicates, as there are costs in the form of expanding its waiver program provider network which would be in addition to the added burden on their budget. Defendants also assert that they realize no savings unless an individual first enters a nursing home for a sufficiently long period of time. However, Defendant provided no evidence to support these arguments.[16] Beyond conclusory statements in the Response and at the hearing, Defendants have not shown how Plaintiff's cost analysis is flawed, how much an expansion of their provider network would cost, or why an individual must enter a nursing home facility for a certain period of time before Defendants realize any savings. While Defendants may be able to support these contentions on a more developed record, they have not done so here.

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[16] In the May 25 Order originally scheduling the Preliminary Injunction Hearing, the Court ordered the parties to submit all necessary evidence in advance of the hearing in accordance with Rule 4.06(b), Local Rules, United States District Court, Middle District of Florida (Local Rule(s)). Indeed, the hearing was continued in part to allow Defendants to obtain the necessary affidavits to present to the Court.

Additionally, the Court notes that if it costs less on a per day basis to provide in-home services instead of nursing facility care, it is unclear why Defendants would not realize some savings from the start. Defendants' contention appears to be based on the idea that if individuals are able to request and receive in-home services without first submitting to institutionalization, persons who are not truly at risk of institutionalization without state services, would nevertheless request provision of services at state expense. Thus, Defendants would be forced to spend funds for in-home services where no expenditure would otherwise be required. While this concern may have merit in the abstract, it has no application here. Based on the current record, Plaintiff has lost the provider of her necessary care. While her son stepped in to provide that care due to the exigent circumstances, his home and responsibilities in Miami, Florida will not permit him to continue to do so, and Plaintiff has no other source of care. While Defendants have suggested that they believe Plaintiff's actual risk of institutionalization is somewhat speculative, see id. at 62-63, the only evidence in the record supports a finding that Plaintiff is, indeed, on the threshold of involuntary institutionalization, see Haddad Dec. at 4-5; Johns Dec. at 5. Thus, while Defendants may be able to present testimony or evidence clarifying and supporting their concern, they have not done so at this time, and the evidence before the Court strongly suggests that such a concern has no application as to this particular Plaintiff.[17]

Moreover, to the extent Defendants' refusal to provide services is based on its financial structure, the Court notes that budgetary constraints, taken alone, are not enough

[17] The Court expresses no opinion as to the merit of such a challenge by others, under different circumstances, or where the challenge to Defendants' program is mounted on a more global basis.

to establish a fundamental alteration defense. See Pa. Prot. & Advocacy, Inc., 402 F.3d at 381. Factors relevant to a fundamental alteration defense certainly include the state's available resources, as well as its responsibility to other individuals. See Olmstead 527 U.S. at 604; Pa. Prot. & Advocacy, Inc., 402 F.3d at 380. However, Defendants have pointed to no evidence, save for the single statement in the Russell Affidavit I that "[i]f the TBI/SCI Waiver Program were forced by court order to place Ms. Haddad in the program, we would have to reduce services that others in the TBI/SCI Waiver Program are currently receiving." Russell Aff. I at 2. However, where as here, the evidence is in conflict as to whether the TBI/SCI Waiver is actually full, this assertion is insufficient to support a fundamental alteration affirmative defense. Moreover, Defendants have failed to address other funding alternatives or to explain how being required to provide services to Plaintiff will undermine their ability to provide proper care to the state's disabled population. Indeed, Defendants provided no evidence that providing services to Plaintiff would cause their programs to suffer or be inequitable given the state's responsibility to provide for the care and treatment of its diverse population of persons with disabilities. Such evidence would certainly have been relevant to Defendants' fundamental alteration defense.

Additionally, the Court finds that on the current limited record, Defendants have simply failed to show that they have a comprehensive, effectively working plan in place to address unnecessary institutionalization. See id. at 381-82 (finding a comprehensive effective plan to be a prerequisite to mounting a fundamental alteration defense). In discussing the fundamental alteration defense, the Court in Olmstead recognized that if a state "had a comprehensive, effectively working plan for placing qualified persons with

[disabilities] in less restrictive settings, and a waiting list that moved at a reasonable pace, not controlled by the state's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met" and the Court would have no reason to interfere. Olmstead, 527 U.S. at 605-606. Following this guidance, in Arc of Washington State Inc. v. Braddock, 427 F.3d 615, 621 (9th Cir. 2005), the Ninth Circuit determined that the state of Washington's waiver program provided such an effective comprehensive plan such that the ADA required no modification. In doing so, the court noted that the waiver program was full, had a waiting list with turnover, all eligible individuals had an opportunity to participate in the program once space became available, slots had been increased when appropriate, expenditures more than doubled despite significant cutbacks or minimal budget growth in the agencies, and the institutionalized population declined by 20%. See id. at 621.

The record before the Court contains no similar evidence. Defendants have only shown that the various waiver programs have increased in size and expenditures. See Hudson Aff. at 1-3; see also Makin ex rel. Russell v. Haw., 114 F. Supp. 2d 1017, 1035 (D. Haw. 1999) (only showing an effort to decrease waiting list by increasing slots, without evidence of a plan, did not show that the state was complying with the ADA). However, this does not address the effectiveness of the TBI/SCI Waiver program. Indeed, Defendants were unable to provide the Court with even the most basic factual information in regard to the waiver program and its waiting list. Defendants did not know Plaintiff's place on the waiting list beyond the fact that she was not in the top forty-five. See Tr. at 51-52. Defendants provided no information as to the average time spent on the waiting list or the rate of turnover, see id. at 54, 102-03, although Plaintiff has been waiting for approximately

two-and-a-half years. Defendants' evidence was in conflict as to whether the TBI/SCI Waiver program was full. See id. at 60-62; 96-98. While Defendants argued that they are committed to decreasing the institutionalized population, they did not present evidence that it has steadily declined.[18] Indeed, contrary to Defendants' assertion of a comprehensive effective plan, the evidence suggests that Defendants' plan may well be ineffective given that their last representation to Plaintiff advised:

> [p]resently, the Department of Children and Families does not have funds available (or available openings) to serve additional individuals through these programs. . . . Placement on the waiting list does not ensure future eligibility. Funding is very limited in these programs, and the amount of funding allocated to these programs has not been increased in many years. Unfortunately, moving individuals off the waiting list into these programs does not occur frequently, therefore, we encourage you to continue seeking services from other programs.

January 8, 2010 Letter at 1. Moreover, despite Plaintiff having informed Defendants of the change in her circumstances in March 2010, Plaintiff has not been reassessed in regard to her priority on the waiting list for the TBI/SCI Waiver. See Haddad Dec. at 4; Tr. at 115-16.

Instead of providing evidence that they have in place an efficient comprehensive plan to avoid institutionalization, Defendants offer the alternative that Plaintiff enter a nursing home for at least sixty days and then be transitioned out of the institution and provided in-home services thereafter. See Tr. at 73-75. This proposal simply gives Defendants an alternative funding source for provision of the services Plaintiff requires. Thus, to satisfy Defendants' budgetary structure, an individual must run the gauntlet of institutionalization for at least sixty days in order to receive in-home services. See id. 105-07. Defendants

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[18] Counsel made some representations regarding numbers based on "his understanding" but presented no evidence in support of that understanding.

have, on the current record, failed to show that such a deprivation is necessary to effectively provide care and treatment for the diverse population of persons with disabilities. Rather than providing for a proper assessment of need which may obviate the need for individuals to meet such a threshold, Defendants appear to be shifting the unnecessary burden of institutionalization onto Medicaid recipients. Accordingly, on the current record, Defendants' fundamental alteration defense is not sufficiently supported, and Plaintiff established that the law and facts at this stage clearly indicate she is likely to prevail on the merits of her case.

B. IRREPARABLE INJURY

Defendants argue that Plaintiff is unlikely to suffer irreparable injury because she will only be institutionalized temporarily. However, Defendants candidly acknowledge that they cannot assure the length of time in question, or that it is truly finite. Indeed, Defendants admit that upon the expiration of the sixty-day period, Plaintiff, who has been living successfully in the community for the last two and a half years, would have to be assessed by the state and be found to be safe for community placement. Accordingly, all Defendants can guarantee is that Plaintiff will face at least sixty days of institutionalization. See id. at 19, 73-75. The requirement that Plaintiff first enter a nursing home in order to be transitioned out sometime thereafter presents Plaintiff with exactly the kind of uncertain, indefinite institutionalization that can constitute irreparable harm. See Katie A. v. L.A. County, 481 F.3d 1150, 1156-57 (9th Cir. 2007) (though it applied an erroneous legal interpretation of the Medicaid statute, district court found unnecessary institutionalization that would occur absent a preliminary injunction to be irreparable harm); Long, 2008 WL 4571903, at *2 (if preliminary injunction was not issued, plaintiff would have to re-enter

nursing facility, which would inflict irreparable injury); McMillan v. McCrimon, 807 F. Supp. 475, 479 (C.D. Ill. 1992) ("possibility that the plaintiffs would be forced to enter nursing homes constitutes irreparable harm that cannot be prevented or fully rectified by a judgment later"). Moreover, Plaintiff's physician has indicated that institutionalization will be detrimental to Plaintiff's health and well-being. See Johns Dec. at 5 ("if [Plaintiff] were placed in a nursing home she would quickly become depressed and her health would most likely deteriorate"); see also Marlo M. v. Cansler, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) (plaintiffs would suffer regressive consequences); Long, 2008 WL 4571903, at *2 (plaintiff would suffer "enormous psychological blow"). Therefore, Plaintiff clearly established that she is at risk of irreparable injury if required to enter a nursing home.

C. BALANCE OF HARMS

Additionally, Defendants admit that "if [Plaintiff] were to go into a nursing home tomorrow, okay, or today or next week or whatever, then clearly the balance of hardships would tip in her favor. . . . Hypothetically, that if she were to enter a nursing home, then yes, the balance of hardships would tip in her favor." Tr. at 65. But Defendants argue that Plaintiff's entry into a nursing home is speculative, and therefore, if Plaintiff would not be institutionalized for months or a year, the balance of harm would swing in Defendants' favor. See id. However, as previously noted, the Court is satisfied that Plaintiff established that she is, indeed, on the threshold of unnecessary institutionalization. See Haddad Dec. at 4-5; Johns Dec. at 5; Tr. at 83. Accordingly, the balance of harms clearly lies in Plaintiff's favor.

D. THE PUBLIC INTEREST

Likewise, the public interest favors preventing the discrimination that faces Plaintiff so that she may avoid unnecessary institutionalization. See Olmstead, 527 U.S. at 599-01. The public interest also favors "upholding the law and having the mandates of the ADA and Rehabilitation Act enforced," as well as in providing injunctive relief that "will cost less than the alternative care proposed by Defendants. As the funding originates from tax dollars, the public interest clearly lies with maintaining Plaintiffs in the setting that not only fulfills the important goals of the ADA, but does so by spending less for Plaintiffs' care and treatment." See Marlo M., 679 F. Supp. 2d at 638-39; see also Long, 2008 WL 4571903, at *3.

VI. CONCLUSION

In consideration of the foregoing, the Court determined that Plaintiff made a clear showing that she has a significant and substantial likelihood of succeeding on the merits of her claim, that Defendants' refusal to provide her with in-home based health care services for which she is financially and medically eligible, and which Defendants provide to others through the TBI/SCI Medicaid waiver program violates the ADA; that she will suffer irreparable injury unless the injunction is issued in that she is at imminent risk of being institutionalized in order to obtain the necessary services which Defendants refuse to provide her outside the institutional setting; that the threatened injury to Plaintiff outweighs the possible injury that the limited injunctive relief ordered here may cause Defendants; and

that such an injunction would not disserve the public interest.[19] Accordingly, the Court entered its June 23, 2010 Order granting preliminary injunctive relief in this action.

DONE AND ORDERED in Jacksonville, Florida, this 9th day of July, 2010.

Marcia Morales Howard

MARCIA MORALES HOWARD
United States District Judge

Copies to:

Counsel of Record

[19] Again, the Court cautions that its findings in this Opinion are strictly limited to the unique circumstances currently facing Plaintiff, Michele Haddad, and are based upon the limited record now before the Court. Thus, this Court's determination that preliminary injunctive relief is appropriate should not be interpreted as suggesting that the Court will find such relief warranted under circumstances different from those here, or that Defendants, on a more complete record, cannot establish that such relief would constitute a fundamental alteration of their programs or that they have a comprehensive, effectively working plan for providing services to qualified individuals with disabilities obviating the need for such relief.

Exhibit C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at **http://www.hcfa.gov/medicaid/olmstead/olmshome.htm.**

Sincerely,

Timothy M. Westmoreland
Director

Enclosures
Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

Attachment 4-B "EPSDT and HCBS waivers"

State Medicaid Director – 2

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
National Association of State Medicaid Directors

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Virginia Dize
Director, State Community Care Programs
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Attachment 4-A
Subject: Allowable Limits and State Options in HCBS Waivers
Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

3. ***Access to Services Within a Waiver***: May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

4. ***Sufficiency of Amount, Duration, and Scope of Services***: What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

5. ***Amendments that Lower the Potential Number of Participants***: May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statues, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

> The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

***Avoiding or Minimizing Adverse Effects on Current Participants*:** Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.

- The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.

- The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B
Subject: EPSDT and HCBS Waivers
Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.

- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Exhibit D

09/09/09

Alabama Medicaid Covered Services and Co-payments

Below is a partial listing of the goods and services that Medicaid covers (pays for). For a list of covered services, see the covered services handbook, "Your Guide to Alabama Medicaid."

NOTE: These covered services are for recipients who have full Medicaid benefits.

Dental Services (for children under 21 years of age only): Medicaid pays for a checkup and teeth cleaning once every 6 months.

Doctor Services: Medicaid pays for 14 doctor visits per calendar year. Medicaid also pays for 16 days of doctor's care when the recipient is in a hospital.

Eye Care Services (for adults): Medicaid pays for eye exams and eyeglasses once every 2 calendar years for recipients 21 years of age or older.

Eye Care Services (for children under 21 years of age): Medicaid pays for eye exams and eyeglasses once every calendar year.

Family Planning Services: Family planning services are available to women of childbearing age and men of any age. Medicaid pays for women age 21 and older to have their tubes tied and vasectomies for men age 21 and older. Family planning services **do not** count against regular doctor's office visits.

Hearing Services (for children under 21 years of age only): Medicaid pays for a hearing screening once every calendar year and for hearing aids.

Home Health Services: Medicaid provides for certain medical services in the recipient's home if he or she has an illness, disability, or injury that keeps him or her from leaving home without special equipment or the help of another person.

Hospice Services: Medicaid pays for hospice care for terminally ill persons. There is no limit on hospice days when approved by Medicaid ahead of time. Covered hospice services include nursing care, medical social services, doctors' services, short-term inpatient hospital care, medical appliances and supplies, medicines, home health aide and homemaker services, therapies, counseling services, and nursing home room and board.

Hospital Services: Inpatient Hospital Care – Medicaid pays for 16 inpatient hospital days per calendar year. Coverage is for a semiprivate hospital room (2 or more beds in a room). In certain hospitals, nursing home care services are provided to Medicaid patients who are waiting to go into a nursing home. This is called **Post Hospital Extended Care (PEC).**

Hospital Services: Outpatient Care – Medicaid pays for 3 non-emergency outpatient hospital visits per calendar year. There are no limits on outpatient hospital visits for lab work, x-ray services, radiation treatment, or chemotherapy only. Medicaid also pays for 3 **outpatient** surgical procedures per calendar year if the surgeries are done in a place called an **Ambulatory Surgical Center**. Medicaid will pay for emergency outpatient services when there is a certified emergency.

Hospital Services: Psychiatric Hospital Services – Medicaid pays for medically necessary services in a psychiatric hospital for children under 21 years of age if approved by Medicaid ahead of time.

Laboratory and X-Ray Services: Medicaid pays for laboratory and x-ray services when these services are medically necessary.

Maternity Services: Medicaid pays for prenatal (before the baby is born) care, delivery and postpartum (after the baby is born) care. Medicaid also pays for prenatal vitamins.

Mental Health Services: Medicaid pays for treatment of people diagnosed with mental illness or substance abuse. The services received from a mental health center **do not** count against regular doctor's office visits or other Medicaid covered services.

Nurse Midwife Services: Medicaid covers nurse midwife services for maternity care, delivery, routine gynecology services, and family planning services.

Nursing Home Care Services: Medicaid pays for nursing home room and board, medicines prescribed by a doctor and 14 visits from a doctor per calendar year while the recipient is in a nursing home. Medicaid also pays for long term care for mentally retarded persons.

Out-of State Services: Medicaid pays for some medical services only if certain conditions are met.

Prescription Drugs: Medicaid pays for most drugs ordered by the doctor. Many over-the-counter drugs are also covered (paid for). There are some drugs that must be approved by Medicaid ahead of time. Your doctor or pharmacist can tell you which drugs Medicaid Pays for. For most recipients, Medicaid only pays for four (4) brand name drugs each month. Generic drugs are not limited

Renal Dialysis Services: Medicaid pays for 156 outpatient dialysis treatments per calendar year for recipients with kidney failure. Medicaid also pays for certain drugs and supplies.

Transplant Services: Medicaid pays for some organ transplants.

Transportation Services: Ambulance Services – Medicaid pays for ambulance services only when medically necessary.

Transportation Services: Non-Emergency Transportation Services – Medicaid helps cover the cost of transportation to and from medically necessary appointments for Medicaid recipients who have no other way to get to their appointments without evident hardship. To find out about obtaining a voucher for a ride, call the Non-Emergency Transportation Program at 1-800-362-1504. The call is free.

Well Child Checkup Program (also known as the EPSDT Screening Program): The Well Child Checkup Program is for all Medicaid eligible children under 21 years of age, **except** those who receive pregnancy-related or family planning services only. Additional doctor visits, extra hospital days, and medically necessary services are available, if needed, to those children who have had their well child checkups.

Co-payments for Medicaid Services

Recipients may be asked to pay a small part of the cost (co-payment) for some medical services. Medicaid will pay the rest. Providers cannot charge any additional amount other than the co-payment for Medicaid covered services. Co-payments for Medicaid covered services are in the amounts shown below:

Services with Co-payments:	**Co-payment Amounts:**
Doctor visits	$1 per visit
Visits to health care centers	$1 per visit
Visits to rural health clinics	$1 per visit
Inpatient hospital	$50 each time you are admitted
Outpatient hospital	$3 per visit
Prescription drugs	50 cents to $3 per prescription
Medical equipment	$3 per item
Supplies and appliances	$1 for each purchase
Ambulatory surgical centers	$3 per visit

You do not have to pay a co-payment if you are a Medicaid recipient who is:

* In a nursing home,
* Under 18 years of age,
* Pregnant, or
* Receiving family planning services.

The following services do not require a co-payment:

* Birth Control (Family Planning) services,
* Case management services,
* Chemotherapy,
* Dental services for children under 21 years of age,
* Doctor fees if surgery was done in the doctor's office,
* Doctor visits if you are in a hospital or a nursing home,
* Emergencies,
* Home and community services for the mentally retarded, or the elderly and physically disabled,
* Home health care services,
* Mental health and substance abuse treatment services,
* Preventive health education services,
* Physical therapy in a hospital outpatient setting,
* Radiation treatments, or
* Renal dialysis treatments.

All information in this handout is general and may change. To make sure you get the latest information, call the Alabama Medicaid Agency. For a list of covered services, see the covered services handbook, "Your Guide to Alabama Medicaid."
If you have questions, call the Recipient Inquiry Hotline at 1-800-362-1504. The call is free. (For the hearing impaired, the TDD number is 1-800-253-0799. The call is free.)