

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Pennsylvania** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**

Consolidated Waiver

C. **Waiver Number: PA.0147**

Original Base Waiver Number: PA.0147.91.R4

D. **Amendment Number: PA.0147.R04.01**

E. **Proposed Effective Date:** (mm/dd/yy)

07/01/09

Approved Effective Date: 07/01/09

Approved Effective Date of Waiver being Amended: 07/01/07

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to revise service definitions to more clearly outline the scope and when applicable, limits of the service. The revised service definitions also support the implementation of a consistent reimbursement methodology for waiver services.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input type="checkbox"/> Appendix B – Participant Access and Eligibility	

<input checked="" type="checkbox"/> Appendix C – Participant Services	C-1/C-3
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	E-1-g
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-2

B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Consolidated Waiver

C. **Type of Request:** amendment

Original Base Waiver Number: PA.0147

Waiver Number: PA.0147.R04.01

Draft ID: PA.03.04.01

D. **Type of Waiver** (*select only one*):

Regular Waiver ▼

E. **Proposed Effective Date of Waiver being Amended:** 07/01/07
Approved Effective Date of Waiver being Amended: 07/01/07

1. Request Information (2 of 3)

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

- Hospital

Select applicable level of care

- Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

- Nursing Facility**

Select applicable level of care

- Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

- Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

People with a diagnosis of mental retardation, as defined in Bulletin 00-99-14, Individual Eligibility for Medicaid Waiver Services, or any approved revisions by ODP.

1. Request Information (3 of 3)

- G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- Not applicable**
- Applicable**

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a) of the Act and described in Appendix I**
- Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

- §1915(b)(1) (mandated enrollment to managed care)**
- §1915(b)(2) (central broker)**
- §1915(b)(3) (employ cost savings to furnish additional services)**
- §1915(b)(4) (selective contracting/limit number of providers)**
- A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

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

The Consolidated Waiver has been developed to emphasize deinstitutionalization and to prevent or minimize institutionalization. The Consolidated Waiver is designed to help persons with mental retardation live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models.

The Department of Public Welfare, as the State Medicaid agency, retains authority over the administration and implementation of the P/FDS Waiver. The Office of Developmental Programs (ODP), as part of the Medicaid agency, is responsible for the development and distribution of policies, rules, and regulations related to waiver operation. All services and supports funded under the waiver are authorized by local Administrative Entities pursuant to an Administrative Entity Operating Agreement with ODP. An Administrative Entity (AE) is a County

Mental Health/Mental Retardation (MH/MR) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved Consolidated Waiver. The Agreement establishes the roles and responsibilities of AE's with respect to fiscal and program administration.

AE's may purchase fiscal and program administrative services in accordance with the Operating Agreement. When administrative services are purchased by the AE, the AE continues to retain ultimate responsibility for compliance with its Agreement with the Department for the administration of waiver-funded services. The AE must also ensure that any purchased administrative services are established in writing pursuant to a contract or agreement. Costs of purchased administrative services shall be paid through the Department's allocation to the AE for administration of the waiver. Waiver service funding cannot be used for these purposes. AE's must retain the following responsibilities as per the Operating Agreement:

1. Purchased Fiscal and Administrative Services.
2. Administrative Functions, related to the final decision for each function.
3. Review, Approval, and Authorization of Services, specifically related to the review and authorization of services.
4. Quality Management.
5. Participation in Training.

AE's are responsible to ensure the development of individual support plans (ISPs), based on the results of a needs assessment, using the standardized Home and Community Services Information System (HCSIS) ISP format. AE's are responsible to ensure that ISP's are developed and authorized prior to the receipt of waiver services, and include the services and supports necessary to meet the assessed needs of waiver participants. AE's are responsible to ensure that ISP's are updated on at least an annual basis, and whenever necessary to reflect changes in the need of waiver participants.

The State assures that this waiver will be compliant with all applicable regulations related to case management no later than 3/3/2010. Any amendments required to achieve such compliance will be submitted to CMS at least 90 days in advance of that date.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="" type="radio"/> Yes. This waiver provides participant direction opportunities. Appendix E is required.
<input type="radio"/> No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

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

- Not Applicable**
- No**
- Yes**

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

- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
A draft of the Consolidated waiver has been distributed for a period of public comment.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Pennsylvania
Zip: 17105
Phone: (717) 783-1003 **Ext:** TTY
Fax: (717) 787-6583
E-mail: ksvalbonas@state.pa.us

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

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: Pennsylvania
Zip:
Phone: **Ext:** TTY
Fax:
E-mail:

8. Authorizing Signature

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

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

Signature:
State Medicaid Director or Designee
Submission Date:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:

	<input type="text" value="Harrisburg"/>
State:	Pennsylvania
Zip:	<input type="text" value="17105"/>
Phone:	<input type="text" value="(717) 787-3700"/>
Fax:	<input type="text" value="(717) 787-6583"/>
E-mail:	<input type="text" value="kecasey@state.pa.us"/>

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one: do not complete Item A-2*):

- The Medical Assistance Unit.**

Specify the unit name:

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the unit name:

Pennsylvania Office of Developmental Programs (ODP)

Do not complete item A-2.

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

Appendix A: Waiver Administration and Operation

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*: ODP retains the authority over the administration of the Consolidated Waiver, including the development of waiver-related policies, rules, and regulations. In addition to regulations, waiver-regulated policies and rules are distributed by ODP through ODP Bulletins. ODP also retains the authority for all administrative decisions and supervision of AE's, as well as other contracted entities. ODP provides information and technical assistance to AE's through ODP Academy Training sessions, targeted technical assistance, and upon request.

ODP delegates the following responsibilities to AE's through the Administrative Entity Operating Agreement and applicable regulations and policies:

1. Evaluation and reevaluation of level of care as specified in the approved waivers.
2. Providing waiver applicants who are likely to be determined eligible for an ICF/MR level of care with service preference between home and community based and institutional services.
3. Ensuring Prioritization of Urgency of Need for Services (PUNS) forms are completed to assign waiver applicants with a category of need for waiver services.
4. Enrollment of eligible applicants subject to the availability of waiver capacity.
5. Ensuring fair hearing and appeal rights are explained to waiver applicants and participants, provide Departmental fair hearing appeal information and notice, and providing needed assistance in filing fair hearing requests, as per the Operating Agreement and Departmental policies.
6. Ensuring the completion of needs assessments to inform the planning process.
7. Ensuring the timely development and implementation of ISP's using the processes and format outlined by the Department.
8. Ensuring the revision of ISP's at least annually and as needed to respond to changes in need of waiver participants.
9. Ensuring needed waiver services and supports and supports coordination providers are located.
10. Ensuring that ISP monitoring takes place at a frequency necessary to ensure the health and welfare of waiver participants and the implementation of the ISP; with a minimum frequency as designated in the Waiver and Operating Agreement.
11. The qualification of waiver providers using the qualification criteria outlined in the current approved Consolidated Waiver, with the exception of supports coordination providers. The AE is responsible to ensure providers they are qualifying hold a signed Medical Assistance Agreement with ODP.
12. Providing waiver participants with free choice of willing and qualified waiver providers.
13. Authorization of all approved waiver funded services, rates and charges.
14. Until June 30, 2009, entering into a standard AE/Waiver Provider contract with waiver providers, with the exception of unlicensed individuals and vendors providing services through an Intermediary Service Organization.
15. Payment of waiver providers for waiver claims for authorized services until June 30, 2009 as per the Waiver and Operating Agreement.
16. Monitoring providers to ensure compliance with the standard AE/Waiver Provider contract and the ODP Medical Assistance Provider Agreement.
17. Hearing waiver provider contract disputes as per 55 PA Code Chapter 4300.
18. Monitoring of all assigned fiscal and program administrative services pursuant to a signed contract or agreement.
19. The accountability for the expenditure of waiver funds subject to policies and procedures defined by ODP.
20. The submission of the quarterly waiver expenditure report, to ODP within fourteen (14) working days of the end of a quarter.
21. The submission of annual waiver reports, including reconciled exception reports; and the income and expenditure reports, or other ODP approved submissions, by September 15 of every year, unless otherwise directed by ODP.
22. Compliance with the revised Office of Management and Budget Circular A-133, titled: Audits of States, Local Governments, and Non-Profit Organizations; Title 45, CFR 74.26, and any other applicable law or regulation promulgated by the federal government.
23. Completion of a self-review of the AE's administrative services using the ODP's review protocol.

AE's may purchase fiscal and program administrative services, as per the Operating Agreement. When such services are purchased, the AE retains responsibility for the function and compliance with the Operating Agreement.

- **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

- **Not applicable**

- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

ODP retains the authority over the administration of the Consolidated Waiver, including the development of waiver-related policies, rules, and regulations. In addition to regulations, waiver-regulated policies and rules are distributed by ODP through ODP Bulletins. ODP also retains the authority for all administrative decisions and supervision of non-state public agencies that conduct waiver operational and administrative functions. ODP delegates functions to County MH/MR Programs through an Operating Agreement. The County MH/MR Programs implement these responsibilities and meet the requirements specified in the approved Operating Agreement. See Appendix A-3 for a detailed list of responsibilities.

ODP will utilize County MH/MR Programs as the AE, unless a County MH/MR Program is unwilling or unable to perform waiver operational and administrative functions as per the AE Operating Agreement.

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

ODP retains the authority over the administration of the Consolidated Waiver, including the development of waiver-related policies, rules, and regulations. In addition to regulations, waiver-regulated policies and rules are distributed by ODP through ODP Bulletins. ODP also retains the authority for all administrative decisions and supervision of non-governmental, non-state entities that conduct waiver operational and administrative functions. ODP has contracted with one non-governmental administrative entity. Pennsylvania intends to utilize an administrative entity in cases where the County MH/MR Program cannot or chooses not to participate in the waiver program. ODP delegates functions to the Administrative Entity through an Operating Agreement. The Administrative Entity implements these responsibilities and meets the requirements specified in the approved Operating Agreement. See Appendix A-3 for a detailed list of responsibilities.

Appendix A: Waiver Administration and Operation

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

ODP remains the ultimate authority for waiver policies, rules, and regulations; and retains the ultimate authority on all administrative decisions. ODP retains the responsibility for the supervision and assessment of performance of AE's, and other contracted entities. ODP provides information and technical assistance to AE's through ODP Academy Training sessions, targeted technical assistance, and upon request.

ODP is responsible for the assessment of performance of AE's and other contracted entities. A significant portion of ODP monitoring

includes an assessment of Supports Coordination activity to ensure compliance with the approved waiver. In addition, ODP requires AE's to conduct monitoring of Supports Coordination Organizations.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: ODP retains authority over the administration of the Consolidated Waiver. This includes development of regulations and waiver-related policies and rules through ODP Bulletins. ODP retains authority for administrative decisions and supervision of AEs. ODP provides information and technical assistance to AEs through ODP Academy sessions and upon request. AEs perform waiver operational and administrative functions pursuant to a signed Operating Agreement with ODP. ODP oversees performance of AEs through a variety of mechanisms, including service reviews, complaint reviews, incident management (IM), risk management (RM) and the AE Oversight process.

ODP conducts a Service Review of fair hearing requests for participants that relate to the denial, reduction, suspension, or termination of waiver services. Service Reviews are used to ensure AE compliance with waiver policies. ODP sends Service Review findings to the AE, the participant/family, and DPW's Bureau of Hearings and Appeals; and monitors implementation of Service Review findings. Upon receipt of the Service Review findings, the participant/family may continue the fair hearing process or withdraw their hearing request.

ODP receives complaints and concerns through a toll-free Customer Service Number. Each customer service call follows an ODP protocol, including referral to the appropriate ODP Regional Office or Bureau, and timely follow up. ODP Regional Offices review referred calls and follow up through a variety of ways, including investigations, unannounced inspections and referral to AEs. Complaints are also reviewed by ODP Regional RM committees.

ODP Regional Offices review HCSIS incident reports to ensure appropriate action occurred to protect the individual's health, safety, and rights. Areas of concern are communicated to the provider/entity and AE. ODP Regional Offices also conduct a management review 24 hour incident reports (see Appendix G-1) to determine:

1. Appropriate action to protect the individual;
2. Correct incident categorization;
3. Certified investigation occurred when needed;
4. Proper safeguards are in place; and
5. Corrective action has or will take place.

Each ODP Regional Office has an internal RM Committee that meets at least monthly. RM teams are used to promote the health and safety of participants by reducing the frequency and severity of adverse events through risk identification, evaluation, planning and implementation. RM meetings involve review of regional data including primary and secondary incident categories, problem-prone and high risk incidents, certified investigations, death reports, licensing results and Health Care Quality Unit reports.

Additional information is obtained through Independent Monitoring for Quality (IM4Q), a statewide method that PA has adopted to independently review quality of life issues for people in the MR system that includes an annual sample of waiver participants. IM4Q monitors satisfaction and outcomes of people receiving services through indicators organized into areas of satisfaction, dignity and respect, choice and control, inclusion, and physical setting. Interview results are entered into HCSIS and when necessary used to make service changes. IM4Q data is aggregated into provider, AE, regional and statewide reports. Aggregate data is used for continuous quality improvement purposes by ODP, AE and provider quality groups.

In April 2007, ODP began a new process to monitor the performance of AEs. The new AE Oversight involves continuous review of specific indicators consisting of: 1. Review of reports from ODP's Division of Program Analysis; 2. Input from Regional leads on Quality, Employment, Lifesharing, IM4Q, Financial Management, Licensing and RM; 3. Sample reviews of ISP's, PUNS data, monitoring and service notes; and 4. Onsite visits to the AE and people receiving services. An ODP Regional AE Oversight Team is assigned for review and oversight of each AE.

ODP's Central Office Division of Program Analysis generates a seven percent sample of individuals for review of specific indicators. A subset of individuals is targeted for face-to-face interviews. AE Oversight is implemented on a staggered schedule, with a formal onsite review of each AE at least every 2 years.

AREAS OF THE AE OVERSIGHT PROCESS (The following areas are included in the process for calendar years 2007 and 2008. The process will be reviewed and revised as needed.)

A. QUALITY OF LIFE ISSUES

1) ISP Review

The review focuses on timeliness, quality and content of ISPs to address CMS plan assurances. Reports on the timeliness of ISPs and a sample of ISPs are reviewed to ensure individual needs are met and ISPs are revised as needed.

2) Supports Coordination Review

a. Monitoring

Monitoring by supports coordinators is reviewed to determine compliance with frequency and content requirements.

b. Prioritization of Urgency of Need for Services (PUNS)

PUNS forms are reviewed for sampled individuals to determine timeliness and accuracy.

c. Data Integrity

HCSIS information is reviewed to determine its accuracy and completeness.

3) Quality Management (QM) Requirements

Information on the AE QM framework, plan and activities is reviewed. On a continuous basis, the Regional Office contacts the AE QM point person and reports any critical issues to the Regional RM team.

4) IM

IM reports are regularly reviewed by Regional RM teams, and are analyzed to identify trends in AEs. Issues of immediate concern are addressed in a timely fashion. Regional RM Teams provide a summary of trends to the AE Oversight Team.

5) IM4Q

Reviews to ensure compliance with IM4Q guidelines with a summary of performance provided to the Regional AE Oversight Team.

B. ODP INITIATIVES

1) Employment

The Regional Office reviews ISPs to determine compliance with practices to promote employment and provides a summary report to the AE Oversight Team.

2) Lifesharing

The Regional Office reviews ISPs to determine compliance with practices to promote lifesharing and provides a summary report to the AE Oversight Team.

3) Restraint Reduction

The Regional RM team continuously reviews progress of the AE in achieving the state restraint reduction goal of 20% and provides a summary report to the AE Oversight Team.

C. AE CAPACITY

AE capacity is reviewed to ensure adequate staffing levels to meet CMS Assurances and waiver, Operating Agreement and MH/MR Act requirements.

D. RIGHTS

1) Due Process

The AE Oversight Team reviews due process requirements including proper notices, assistance and continuation of services when required. Relevant service review findings are noted for corrective action.

2) Choice

The AE Oversight Team reviews choice requirements through a records review and individual interviews.

3) Service Review

The AE Oversight Team reviews service reviews to identify trends and validate implementation of findings.

E. ELIGIBILITY

1) LOC Determination

The AE Oversight Team reviews a sample of individuals to verify proper procedures were followed for LOC determinations.

2) LOC Determination Concurrence/Non-concurrence

The AE Oversight Team reviews a sample of individuals to evaluate LOC determinations for compliance with current processes.

F. FINANCIAL MANAGEMENT

1) General

The AE Oversight Team reviews a sample of audits for compliance with the Single Audit Act and other requirements. Until all providers are billing PROMISE, the Oversight Team will complete a review of AE billing processes to ensure proper utilization of waiver funds.

2) Rate Setting

The AE Oversight Team reviews a sample of contracts and rate setting spreadsheets to ensure AE compliance with state rate setting guidelines.

3) Financial Reports

The Regional Office reviews waiver reports and any issues are provided to the AE Oversight Team. The Oversight Team reviews

allocation letters from ODP to the AE to determine whether the AE is within the number of allocated waiver capacity.

4) Individual Emergency Services Form (IESF)

The AE Oversight Team determines whether the AE is following IESF procedures to address changes in need of participants.

G. PROVIDER MONITORING

The AE Oversight Team reviews a sample of AE/Provider Contracts to ensure compliance with the standard contract, Medical Assistance Provider Agreement and provider qualifications. AEs will submit copies of contracts to Regional Offices. The Oversight team will ensure that providers have a signed MA Provider Agreement and current license if applicable.

H. OTHER AE FUNCTIONS

1) Record Retention

The AE Oversight Team reviews records to ensure compliance with record retention requirements.

2) Self-Review

The AE Oversight Team reviews AE self-reviews to identify target review areas.

3) Fully Served

The AE Oversight Team reviews waiver participants to evaluate whether they are fully served.

4) Individual Personal Funds

The AE Oversight team reviews management of individual funds for compliance with policies.

Issues identified through ongoing reviews of indicators and informal complaints will be addressed on an as needed basis, and will be used to develop the formal report of AE performance. Additional onsite visits may take place for targeted reviews of noncompliance areas. Formal onsite reviews result in a findings report from ODP to the AE. Findings reports include areas of noncompliance and recommendations for improvement. AE's are required to complete a plan of correction to address findings in the review report. Plans of correction are subject to review and approval by ODP. ODP notifies the AE of approval of the plan of correction, and validates corrective activities.

ODP's central internal review body, the ODP Leadership Board, oversees and monitors all processes and functions related to ODP's QM Strategy (see Appendix H2 for a detailed list of responsibilities). In addition, the ODP Central Office Waiver Assurance Oversight Group is responsible to review statewide performance and identify system improvements (see Appendix H2 for a detailed list of responsibilities); and the ODP Regional Office Waiver Assurance Oversight Group is responsible to review regional performance and identify regional improvements (see Appendix H2 for a detailed list of responsibilities).

AE noncompliance with the Operating Agreement is addressed through the following remedies. While remedies will generally follow a progressive path, ODP reserves the right to deviate from this path for significant issues of noncompliance.

1. Notification of the noncompliance to the AE;
2. Technical assistance to the AE by ODP;
3. A required plan of correction;
4. Freezing enrollment by the AE pending an acceptable plan of correction; and/or
5. Termination or non-renewal of the Agreement.

If ODP freezes enrollment by an AE, another AE will be used for emergency enrollments.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
 In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met			

	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Recruit providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	3	<input type="text"/>	<input checked="" type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Residents of licensed Personal Care Homes are excluded from enrollment in the Consolidated Waiver.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
 - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	16942
Year 2	17559
Year 3	17619
Year 4 (renewal only)	17646
Year 5 (renewal only)	17646

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

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Money Follows the Person

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Money Follows the Person

Purpose (*describe*):

DPW has been awarded a Money Follows the Person Grant to serve people from various program offices including ODP. The Department is required to ensure that MFP participants receive continuity of care during and after the twelve months of demonstration grant funding. To ensure this continuity of care, ODP has chosen to reserve a specified number of slots via this waiver amendment.

Describe how the amount of reserved capacity was determined:

In accordance with recommendations from the ODP Planning Advisory Committee, the stakeholder group comprised of at least 51% people with disabilities and family members, ODP plans to provide opportunities for people to move out of large, congregate ICF/MR facilities and nursing homes through the MFP demonstration grant.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	60
Year 4 (renewal only)	27
Year 5 (renewal only)	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
 - The waiver is not subject to a phase-in or a phase-out schedule.**
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

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

Waiver capacity generally is allocated to the AE based upon the history of usage and a 4 percent turnover rate. If the Legislature appropriates additional funding, additional waiver capacity is allocated based on waiting list information captured through the standardized Prioritization of Urgency of Need for Services (PUNS) form and entered in HCSIS.

A person is assigned a category of need through PUNS, based on a series of standard questions. The current PUNS categories are emergency, which is used if the person needs services within the next six (6) months; critical, which is used if the person needs

services more than six (6) months away, but less than two (2) years away; and planning, which is used for people who need services more than two (2) years, but less than five (5) years away. People with an emergency PUNS category are prioritized for funding.

If unused capacity exists in an AE, the capacity may be held and authorized at the state level or the state may reallocate slots to another AE through a re-budget process. Participants may receive services anywhere in the Commonwealth.

ODP will review information obtained from a Pennsylvania State University study regarding the distribution of demographics and services across the Commonwealth, and use the information, as appropriate in rebalancing the distribution of waiver capacity beginning in fiscal year 2009/2010. The anticipated outcome of the study is a statewide formula and process for distributing waiver slots to AE's. Rebalancing would take place through the allocation of waiver slots to AE's, based on the study and resulting formula.

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

The AE is responsible to evaluate the PUNS categorization of a waiver applicant when making most service selection decisions. Waiver applicants assessed by the AE as having an emergency need receive preference for waiver funding before those assessed in critical or planning categories of need. ODP retains ultimate authority to select waiver applicants for waiver enrollment based on an applicant's unique emergency circumstances.

Other policies that apply include:

- Participant Access and Eligibility (see the Addendum to Appendix B-6:a:ii)
- Level of Care Evaluations and Reevaluations (see Appendix B-6:b and B-6:c)
- Level of Care Criteria (see Appendix B-6:d)
- Level of Care Instruments (see Appendix B-6:e)
- Process of Level of Care Evaluation/Reevaluation (see Appendix B-6:f)
- Reevaluation Schedule (see Appendix B-6:f)
- Qualifications of Individual who Perform Reevaluations (see Appendix B-6:g)

The AE is also responsible to use PUNS data to develop the annual AE plan and estimate of expenditures.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. State Classification.** The State is a (*select one*):
- §1634 State
 - SSI Criteria State
 - 209(b) State
- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

All other mandatory and optional groups under the State Plan are included.

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):
- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

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

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the State plan**

Select one:

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable**
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

[Empty box]

Specify the amount of the allowance (*select one*):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: [] If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

[Empty box]

iii. Allowance for the family (*select one*):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: [] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

[Empty box]

- Other

Specify:

[Empty box]

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

- The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

If a waiver participant is receiving at least one of the following waiver services, ODP requires the provision of a service at least once each calendar month in order for the participant to be determined in need of waiver services:

- Home and Community Habilitation (Unlicensed)
- Licensed Day Habilitation
- Prevocational Services
- Residential Habilitation
- Companion
- Supported Employment

- Transitional Work Services
- Transportation

The following are exceptions to the requirement for at least one waiver service each calendar month:

1. For waiver participants living in their own home or the home of a legally responsible individual/relative/legal guardian, the State requires the provision of at least one unit of a waiver eligible service monthly with the following exceptions:

- The waiver participant is admitted to a medical facility (for example, hospital, rehabilitation facility, nursing home) for up to 45 calendar days;
- The provider is unable to provide services for that period of time due to provider capacity issues. Should this occur the provider must document why they were unable to provide service and provide a detailed corrective action plan to address such situations in the future. There must also be documentation that the choice of other qualified providers has been offered to the participant; or
- The waiver participant living at home requires an emergency relocation (for example, due to a fire) and is unable to access waiver services for up to 45 calendar days.

2. For waiver participants living in waiver-funded residential settings, the State requires the provision of at least one unit of a waiver eligible service monthly unless the participant is absent due to therapeutic or medical leave, consistent with ODP's policies.

If a waiver participant is only receiving one or more of the following waiver services, ODP does not require the provision of a monthly service to indicate a need for waiver services. If a monthly service is not provided, ODP requires a face-to-face ISP monitoring contact by Supports Coordinators at least once every calendar month, regardless of the participant's living arrangement. At least two of the face-to-face visits per calendar year must take place in the participant's home. Deviations of monitoring frequency and location are not permitted for these circumstances.

- Education Support Services
- Homemaker/Chore
- Respite
- Nursing
- Therapy Services
- Supports Broker Services
- Assistive Technology
- Behavioral Support
- Home Accessibility Adaptations
- Vehicle Accessibility Adaptations
- Home Finding
- Specialized Supplies

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

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

- Other**

Specify:

A Qualified Mental Retardation Professional (QMRP) is responsible for performing level of care evaluations and reevaluations. QMRP's are employed by AE's or a Supports Coordination Organization.

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

Qualified Mental Retardation Professional (QMRP): The QMRP must have either a master's degree or above from an accredited college or university and one year of work experience working directly with persons with mental retardation; or a bachelor's degree from an accredited college or university and two years work experience working directly with persons with mental retardation; or an

associate's degree or 60 credit hours from an accredited college or university and four years work experience working directly with persons with mental retardation.

The AE is responsible to ensure that no conflict of interest exists in the level of care evaluation/reevaluation process. Evaluations/reevaluations will not be accepted from:

1. A QMRP employed or affiliated with an ICF/MR or nursing facility from which an individual is being referred or discharged.
2. A QMRP employed or affiliated with an agency that provides or may provide Waiver funded services for the individual. The only exception to this rule is a QMRP employed or affiliated with a Supports Coordination Entity; this QMRP may certify an individual's ICF/MR level of care as long as the individual:
 - a. Is not on the QMRP's current caseload.
 - b. Has not been on the QMRP's past caseload.
 - c. Is not anticipated to be added to the QMRP's current caseload for a period of 365 calendar days.

AEs may contract with another agency or independent professional who meets the criteria defined in 42 CFR 483.430(a) to obtain a QMRP certification of need for an ICF/MR level of care in order to ensure a conflict-free determination.

Level of care evaluations/reevaluations by AE staff and supports coordinators are generally acceptable as long as these persons meet the QMRP requirements and are not directly involved in the provision of service for the individual.

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

The AE's are responsible to ensure the completion of an evaluation of need for level of care, and timely renewal annually thereafter. The initial evaluation and any reevaluation will be performed by a QMRP, as defined in 42 CFR 483.430(a).

There are three fundamental criteria that must be met prior to an individual being determined eligible for an ICF/MR level of care:

1. Require active treatment;
2. Have a diagnosis of mental retardation; and
3. Be recommended for an ICF/MR level of care based on a medical evaluation.

An individual shall meet the criteria for requiring active treatment only when a QMRP, based on review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supervised program of activities, experiences or therapies that are necessary for assisting the individual to function at his/her greatest physical, intellectual, social or vocational level.

For individuals for whom no further positive growth is demonstrated, the criteria shall be met by the QMRP's determination that a program of active treatment is needed to prevent regression or loss of current optimal functional status. The review of the individual's social and psychological history shall consist of an interview with the individual and/or members of the individual's family and a review of notes, observations and reports from educational facilities, human service agencies, hospitals and other reliable sources when available. The review shall be done in conjunction with the individual's team.

Individuals who do not qualify for an ICF/MR level of care will be referred as appropriate to other agencies and resources.

In April 2007, ODP began a new statewide process to monitor the performance of AE's to determine compliance with waiver requirements and policies. The new AE Oversight includes a section related to eligibility that includes indicators specific to level of care evaluations and reevaluations. The new AE Oversight requires an AE corrective action plan for issues of noncompliance.

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The same process is used for both the evaluation and subsequent reevaluations.

There are three fundamental criteria that must be met prior to an individual being determined eligible for an ICF/MR level of care:

1. Require active treatment;
2. Have a diagnosis of mental retardation; and
3. Be recommended for an ICF/MR level of care based on a medical evaluation.

An individual shall meet the criteria for requiring active treatment only when a QMRP, based on review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supervised program of activities, experiences or therapies that are necessary for assisting the individual to function at his/her greatest physical, intellectual, social or vocational level.

Currently ODP monitors level of care evaluations through the AE Oversight process. AE Oversight is a statewide process to monitor the performance of AE's to determine compliance with waiver requirements and policies. AE Oversight includes a section related to eligibility that includes indicators specific to level of care evaluations and reevaluations. The AE Oversight requires an AE corrective action plan for issues of noncompliance.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

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

Recertification of need for an ICF/MR level of care shall be made within 365 days of the individual's initial certification and subsequent anniversary dates of recertifications. The recertification shall be completed through a medical evaluation and by a QMRP and shall be based on the individual's continuing need for an ICF/MR level of care, his/her progress toward meeting plan objectives, the appropriateness of the individual support plan, and consideration of alternate methods of care.

ODP currently monitors the timeliness of reevaluations through the AE Oversight process. AE Oversight, which began in April 2007, includes an indicator specific to reevaluations, "LOC reevaluations are completed at least annually for all waiver participants". Identified issues of noncompliance will require an AE corrective action plan.

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

Records are maintained at the AE office where the participant is currently registered, as per the AE Operating Agreement.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

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

The AE is required to assure that all individuals requesting services who are likely to require an ICF/MR level of care, or their legal representatives, are informed of feasible home and community-based services funded under the waiver. Feasible alternatives include sufficient and appropriate home and community based services and support that the individual needs or is likely to need in the home and community. This requirement must be met before an individual is given the choice of service preference to receive Medicaid funded services in an ICF/MR or in their home and community under the waiver.

The AE is required to ensure that the waiver participant is free to choose services in any Pennsylvania county. The AE responsible for the geographic area where the individual resides or is planning to reside is required to provide information about both home and community-based services and ICF/MR services, and to assist the individual or his/her legal representative in contacting home and community-based service providers, other AE's and ICF's/MR as requested. AE's that receive requests for information about services in a geographic area outside of the AE's responsibility are required to provide the requested information along with other assistance that may be necessary.

ODP currently utilizes the following forms to document waiver requests and service preference: DP457 Home and Community Based or ICF/MR Application and Service Delivery Preference Form and DP458 Home and Community Based Services Waiver for Individuals with Mental Retardation Notice of Right to Fair Hearing.

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

Completed forms are maintained at the AE offices where the participant is registered, as per the AE Operating Agreement.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

Each AE providing federally funded services is required to have and implement policies/procedures for ensuring language assistance services to people who have limited proficiency in English, as per Bulletin 00-04-13, Limited English Proficiency.

The policies/procedures must include a statement noting that each individual will be assessed regarding their proficiency in the English language; that documentation will be maintained in the individual's record indicating the individual's need for language assistance and the resources utilized to provide this assistance; the assessment of language assistance resources and the development of a resource bank accessible to all staff members needing to provide services to a person with limited English proficiency; a procedure for ongoing staff training; and a procedure for monitoring compliance with Title VI, which can be part of the AE's quality management program.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a

service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Education Support Services
Statutory Service	Home and Community Habilitation
Statutory Service	Homemaker/Chore
Statutory Service	Licensed Day Habilitation
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Employment - Job Finding and Job Support
Statutory Service	Supports Coordination
Extended State Plan Service	Nursing
Extended State Plan Service	Therapy Services
Supports for Participant Direction	Supports Broker Services
Other Service	Assistive Technology
Other Service	Behavioral Support
Other Service	Companion
Other Service	Home Accessibility Adaptations
Other Service	Home Finding
Other Service	Specialized Supplies
Other Service	Transitional Work Services
Other Service	Transportation
Other Service	Vehicle Accessibility Adaptations

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Education

Alternate Service Title (if any):

Education Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Education support services consist of special education and related services as defined in Sections (15) and (17) of IDEA to the extent that they are not available under a program funded by IDEA or available for funding by OVR. Educational support services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a General Educational Development (GED) degree, and support to the participant to participate in an apprenticeship program.

The service may be provided by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Education Support Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certification required by the PA Department of Education (or contiguous state) for the subject being taught.

Other Standard (*specify*):

1. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Education Support Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Certification required by the PA Department of Education (or contiguous state) for the subject being taught.

Other Standard (specify):

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service:

Alternate Service Title (if any):

Home and Community Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This is a direct service (face-to-face) provided in home and community settings to protect health and welfare to assist individuals in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, therapeutic activities, personal adjustment, relationship development, socialization, and use of community resources. This service may not be provided in licensed settings, unless it is provided as Residential Enhanced Services. This service is not a licensed residential service; for residential services, see Residential Home and Community Habilitation Licensed Homes and Unlicensed Homes.

Agency-based providers of Unlicensed Home and Community Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their ISPs. For these providers, transportation costs are included in the Habilitation rate. Transportation included in the rate for Unlicensed Home and Community Habilitation may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

Home and Community Habilitation is a service that may be provided to individuals in their own home or in other community settings not subject to licensing regulations. This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP's travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Home and Community Habilitation consists of services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Through the provision of this service individuals learn, maintain, or improve skills through their participation in a variety of everyday life activities. They learn and use skills in the context of these activities; this is considered a functional approach to the delivery of

services. These activities must be necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life. Services must be provided in a manner that protects the individual's health and welfare.

In addition to supporting individuals in activities typically associated with those occurring in their homes and their community, the Home and Community Habilitation service may also be used to provide staff assistance to support individuals in the following ways:

1. Habilitation provided in home and family settings that are not subject to Department licensing or approval, when the provider of habilitation meets established requirements/qualifications.
2. Support that enables the individual to access and use community resources such as instruction in using transportation, translator and communication assistance, and services to assist the individual in shopping and other necessary activities of community life.
3. Support that assists the individual in developing or maintaining financial stability and security, such as plans for achieving self-support; general banking; personal and estate planning; balancing accounts; preparing income taxes; and recordkeeping.
4. Support that enables an individual to participate in community projects, associations, groups, and functions, such as support that assists an individual to participate in a volunteer association or a community work project.
5. Support that enables an individual to visit with friends and family in the community.
6. Support that enables an individual to participate in public and private boards, advisory groups, and commissions.
7. Support that enables the individual to exercise rights as a citizen, such as assistance in exercising civic responsibilities.
8. Support provided during overnight hours when the individual needs the habilitation service to protect their health and welfare. If the individual only needs supervision during overnight hours, the appropriate service is Companion Services.

This service may not overlap with or duplicate Companion Services. This service should be coordinated with any service(s) that may be provided in the Specialized Therapies and Nursing Services category to ensure consistency in services to individuals across service settings.

This service may be provided at the following levels:

- Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:6.
- Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.
- Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.
- Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.
- Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.
- Level 4 - The provision of the service at a staff-to-individual ratio of 2:1.
- Level 4 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home and Community Habilitation (Unlicensed) and Companion Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - Unlicensed Habilitation
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Home and Community Habilitation

Provider Category:

Agency

Provider Type:

Agency - Unlicensed Habilitation

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the habilitation service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for the agency must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the staff agrees to carry out habilitation responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. For levels 3 enhanced and 4 enhanced, the staff must be a Licensed Nurse or have a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Home and Community Habilitation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. At least 18 years of age

2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the individual agrees to carry out habilitation responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the habilitation service
7. Workers' Compensation Insurance, when required by Pennsylvania statute
8. For levels 3 enhanced and 4 enhanced, the staff must be a Licensed Nurse or have a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Homemaker/Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Homemaker services consist of services to enable the individual or the family with whom the individual resides to maintain their private residence. This service can only be provided when a household member is temporarily absent or unable to manage the home, or when no landlord or provider agency staff is responsible to perform the homemaker activities. Homemaker Services must be provided by a qualified homemaker and may include cleaning and laundry, meal preparation, and other general household care. Chore services consist of services needed to maintain the home in a clean, sanitary, and safe condition. This service can only be provided in the following situations:

- Neither the individual, nor anyone else in the household, is capable of performing or financially providing for the function; and
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Chore services consist of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, and/or leaf removal; and yard maintenance. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the individual's residence is excluded from federal financial participation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 40 hours per individual per fiscal year when the individual or family member(s) or friend(s) with whom the individual resides is temporarily unable to perform or financially provide for the homemaker/chore functions. A person is

considered temporarily unable when the condition or situation that prevents them from performing or financially providing for the homemaker/chore functions is expected to improve. There is no limit when the individual lives independently or with family member(s) or friend(s) who are permanently unable to perform or financially provide for the homemaker/chore functions. A person is considered permanently unable when the condition or situation that prevents them from performing or financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform or financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the ISP.

This service is not available to participants residing in agency-owned, rented/leased, or operated homes.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Homemaker
Agency	Homemaker/Chore Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker/Chore

Provider Category:

Individual

Provider Type:

Individual Homemaker

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

1. At least 18 years of age
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker/Chore

Provider Category:

Agency

Provider Type:

Homemaker/Chore Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Licensed Day Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This is a direct service (face-to-face) that must meet the regulatory requirements of 55 Pa.Code Chapter 2380 (Adult Training Facilities) or 6 Pa.Code Chapter 11 (Older Adult Daily Living Centers). Services consist of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development.

Agency-based providers of Licensed Day Habilitation may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does not include transportation to and from the individual's home (including licensed and unlicensed residential settings) and the day service. Transportation included in the rate for Day Habilitation may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

This service may be provided at the following levels:

- Basic Staff Support (CH 2380) - The provision of the service at a staff-to-individual ratio of no less than 1:6.
- Level 1 (CH 2380) - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.
- Level 2 (CH 2380) - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.
- Level 3 (CH 2380) - The provision of the service at a staff-to-individual ratio of 1:1.
- Level 3 Enhanced (CH 2380) - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.
- Level 4 (CH 2380) - The provision of the service at a staff-to-individual ratio of 2:1.
- Level 4 Enhanced (CH 2380) - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.
- Older Adult Day

The service may be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Licensed Day Habilitation

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Adult Training Facilities 55 PA Code Chapter 2380

Older Adult Day Services 6 PA Code Chapter 11

Comparable license for providers based in states contiguous to Pennsylvania

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Licensed under 55 PA Code Chapter 2380 and/or 6 PA Code Chapter 11
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance
4. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the day habilitation service
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the staff agrees to carry out day habilitation responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. For levels 3 enhanced and 4 enhanced, the staff must be a Licensed Nurse or have a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Prevocational Services ▼

Alternate Service Title (if any):

Prevocational Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

This is a direct service (face-to-face) that must meet the regulatory requirements of 55 Pa.Code Chapter 2390 (Vocational Facilities). This service is provided to assist individuals in developing skills necessary for placement in a higher level vocational program and ultimately into competitive employment. The service may be provided as facility-based employment, occupational training, vocational evaluation, a vocational facility, or a work activities center. Facility-based employment focuses on the development of competitive worker traits through the use of work as the primary training method. Occupational training is used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training that is designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment. Vocational evaluation involves the use of planned activities, systematic observation, and testing to accomplish a formal

assessment of the individual, including identification of service needs, potential for employment, and identification of employment objectives. A vocational facility is a premise where habilitative employment or employment training is provided to one or more individuals with disabilities. A work activities center is a program focusing on behavioral and/or therapeutic techniques to enable individuals to attain sufficient vocational, personal, social, independent living skills to progress to a higher level vocational program.

Agency-based providers of Prevocational Services may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does not include transportation to and from the individual's home (including licensed and unlicensed residential settings) and the day service. Transportation included in the rate for Prevocational Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

This service may be provided at the following levels:

- Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:15.
- Level 1 - The provision of the service at a staff-to-individual ratio range of <1:15 to 1:7.5.
- Level 2 - The provision of the service at a staff-to-individual ratio range of <1:7.5 to >1:1.
- Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.
- Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.
- Level 4 - The provision of the service at a staff-to-individual ratio of 2:1.
- Level 4 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.

The service may be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

Handicapped employment as defined in Title 55, Chapter 2390 is not a service that may be funded through the waiver.

This service may not be funded through the waiver if it is available to individuals through a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the individual's file to satisfy assurances that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 as amended and the IDEA.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Prevocational Services 55 PA Code Chapter 2390

Comparable license for providers based in states contiguous to Pennsylvania

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Licensed under 55 PA Code Chapter 2390
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance
4. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the prevocational service
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the staff agrees to carry out prevocational responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. For levels 3 enhanced and 4 enhanced, the staff must be a Licensed Nurse or has a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

These are direct (face-to-face) and indirect services provided in provider owned, rented/leased, or operated residential settings. Services are provided to protect the health and welfare of individuals by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, therapeutic activities, personal adjustment, relationship development, socialization, and use of community resources. Room and board costs are excluded as per Appendix I-5.

Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their individual support plans (ISPs). This includes transportation to and from day habilitation and employment services. Transportation included in the rate for Residential Habilitation Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

The residential home must be located in Pennsylvania, in one of the eligible settings:

1. Child Residential Services (The residential section of 55 Pa.Code Chapter 3800, Child Residential and Day Treatment Facilities):

The 55 Pa.Code Chapter 3800 services that may be funded through the Consolidated Waiver are limited to residential service settings. Child residential services provided in secure settings, detention centers, mobile programs, outdoor programs, and residential treatment facilities accredited by JCAHO (Joint Commission on Accreditation of Healthcare Organizations) may not be funded through the Consolidated Waiver.

2. Community Residential Rehabilitation Services for the Mentally Ill (CRRS), (55 Pa.Code Chapter 5310): CRRS are characterized as transitional residential programs in community settings for individuals with chronic psychiatric disabilities. This service is full-care CRRS for adults with mental retardation and mental illness. Full-care CRRS for adults is a program that provides living accommodations for individuals who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes are excluded.

3. Family Living Homes (55 Pa.Code Chapter 6500): Family Living Homes are somewhat different than other licensed homes as these settings provide for lifesharing arrangements. Individuals live in host family homes and are encouraged to become contributing members of the family unit. Family living arrangements are chosen by individuals and families in conjunction with host families and in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with mental retardation who are not family members or relatives of family members are living. The primary family living provider is eligible for substitute care to provide relief for the provider, based on the needs of the individual and the family living provider.

4. Community Homes for Individuals with Mental Retardation (55 Pa.Code Chapter 6400): A licensed community home is a home licensed under 55 Pa.Code Chapter 6400 where services are provided to individuals with mental retardation. A community home is defined in regulations as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with mental retardation...."

5. Unlicensed Residential Habilitation: Residential Habilitation may be provided in unlicensed provider-owned, rented, leased homes and family living homes:

- Under 55 Pa.Code §6400.3(f)(7) (for Community Homes), which excludes community homes that serve three or fewer individuals with mental retardation 18 years of age or older who need a yearly average of 30 hours or less direct staff contact per week per home; or
- Under 55 Pa.Code §6500.3(f)(5) (for Family Living Homes), which excludes family living homes that provide room and board for one or two individuals with mental retardation 18 years of age or older who need a yearly average of 30 hours or less direct training and assistance per week per home from the agency, AE, or the family.

Residential Home and Community Habilitation may not be provided in Domiciliary Care Homes and Personal Care Homes.

All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. This service may be anywhere in the United States only during temporary travel as per ODP's travel policy. Services may not be provided to individuals who live in licensed residential settings established on or prior to January 1, 1996, with a licensed capacity to provide services to more than ten unrelated individuals, or in homes established after January 1, 1996, with a licensed capacity to provide services to more than four unrelated individuals. Services may be provided to individuals who reside in previously certified ICFs/MR of ten beds or less that have been converted to waiver-funded homes.

Services consist of support to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Residential habilitation is provided for 24 hours a day based on the need of the individual receiving services.

Residential Enhanced Staffing involves three possible components, which are treated as add-on's to the Residential service:

- The provision of the residential habilitation by licensed nurses;
- The provision of supplemental habilitation staffing, as part of the licensed residential service, to meet temporary medical or behavioral needs of the individual; and/or
- The provision of home and community based services other than habilitation (ex. Physical therapy or nursing) as part of the residential service to meet the needs of individuals living there.

Bed Reservation Days may be utilized for temporary absences, which are defined as absences in which an individual is expected to return to the residential setting. The bed reservation days allow reimbursement of a Residential Habilitation provider through the waiver for a maximum of 30 units (days) per participant per fiscal year for temporary absences of waiver participants. This policy is created to ensure that the individual may return to the same residential facility after a therapeutic leave or hospital stay.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Unlicensed Residential Habilitation
Agency	Licensed Residential Habilitation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Unlicensed Residential Habilitation

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the residential habilitation service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the staff agrees to carry out habilitation responsibilities based on the individual's support

plan.

4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15

5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Licensed Residential Habilitation

Provider Qualifications

License (specify):

55 PA Code Chapter 6400

55 PA Code Chapter 6500

55 PA Code Chapter 3800

55 PA Code Chapter 5310

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the residential habilitation service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the staff agrees to carry out habilitation responsibilities based on the individual's support plan.
4. Criminal history check with no offenses that preclude employment under 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.
5. Required background checks as per the Pennsylvania Child Protective Services Law, 23 Pa. C.S. Chapter 63.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Respite services are direct services that are provided to supervise/support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work. Services are limited to individuals residing in private homes (their own home or the home of a relative or friend).

Individuals can receive two categories of respite services: 24-hour respite and 15-minute respite. 24-hour respite is provided for periods of more than 16 hours, and is billed using a daily unit. 24-hour respite for waiver participants is limited to 30 units (days) per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs. 15-minute respite is provided for periods of 16 hours or less, and is billed using a 15-minute unit. 15-minute respite is limited to 480 (15 minute) units per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs.

Federal and State financial participation through the waivers is limited to:

1. Services provided for individuals residing in their own unlicensed home or the unlicensed home of relative, friend, or other family. Respite services are not available for individuals who reside in agency-operated homes.
2. Room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence.
3. Thirty units (days) of 24-hour respite per individual in a period of one fiscal year except when extended by the ODP Regional Office.
5. 480 (15 minute) units of 15-minute respite per individual in a period of one fiscal year except when extended by the ODP Regional Office.

The provision of respite services does not prohibit supporting individuals' participation in activities in the community during the period of respite. The provision of 24-hour respite services does not prohibit individuals' participation in day and employment services.

Respite services may only be provided in the following location(s):

- Individual's home or place of residence located in Pennsylvania.
- Licensed or approved foster family home or family living home located in Pennsylvania.
- Licensed community located in Pennsylvania with an approved program capacity of ten or fewer unrelated individuals if established prior to January 1, 1996 and with an approved program capacity of four or fewer unrelated individuals if established on or after January 1, 1996. The size limitations may be waived by ODP based on individual circumstances and needs.
- Unlicensed home of a provider or individual meeting the qualifications.
- Other community settings such as summer camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by the Department. This includes respite provided during temporary travel anywhere in the United States, as per ODP's travel policy. It also includes the service provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

These services may not be provided in Nursing Homes, Hospitals, or ICFs/MR.

This service may be provided at the following levels:

- Basic Staff Support - The provision of the service at a staff-to-individual ratio of 1:4.
- Level 1 - The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.
- Level 2 - The provision of the service at a staff-to-individual ratio range of 1:1.
- Level 2 Enhanced - The provision of the service with a staff member who is licensed or degreed.

- Level 3 - The provision of the service at a staff-to-individual ratio of 2:1.
- Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Thirty units (days) of long-term respite per individual in a period of one fiscal year except when extended by the ODP Regional Office.
2. 480 (15 minute) units of temporary respite per individual in a period of one fiscal year except when extended by the ODP Regional Office.

Respite services are not available to participants residing in agency-owned, rented/leased, or operated settings.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

- 55 PA Code Chapter 6400 license when provided in community homes for people with mental retardation in Pennsylvania.
- 55 PA Code Chapter 6500 license when provided in family living homes in Pennsylvania.
- 55 PA Code Chapter 3800 license when provided in child residential facilities in Pennsylvania.
- 55 PA Code Chapter 3700 license when provided in licensed foster family homes.
- Comparable license for providers based in states other than Pennsylvania.

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. 55 PA Code Chapter 3800, 6400, or 6500, when applicable
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance
4. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the respite service
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for the agency must meet the following standards:

1. At least 18 years of age

2. Completion of necessary pre/in service training based on the individual support plan.
3. Documentation that the staff agrees to carry out the responsibilities to provide respite based on the individual support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. For levels 2 enhanced and 3 enhanced, the staff must be a Licensed Nurse or have a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. At least 18 years of age
2. Completion of necessary pre/in service training based on the individual support plan.
3. Agreement to carry out the responsibilities to provide respite based on the individual support plan.
4. 55 PA Code Chapter 6350
5. Oversight provided by QMRP meeting requirements of 42 CFR 483.430.
6. Criminal clearances
7. Act 33/Child Abuse Clearance (when service is provided to individuals under age 18).
8. Effective July 1, 2008, Act 73 of 2007 FBI clearance (when service is provided to individuals under the age of 18).
9. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the respite service
10. Workers' Compensation Insurance, when required by Pennsylvania statute
11. For levels 2 enhanced and 3 enhanced, the staff must be a Licensed Nurse or a professional with a Degree (at least 4 year)

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Job Finding and Job Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Supported Employment Services are direct and indirect services that are provided in community employment work sites with co-workers who do not have disabilities for the purposes of finding and supporting individuals in competitive jobs of their choice. Individuals must receive minimum wage or higher. Supported Employment Services consist of paid employment for individuals who, because of their disabilities, need intensive support to perform in a work setting. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by the individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Federal Financial Participation through the waivers may not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

- a. Incentive payments made to an employer of individuals receiving services to encourage or subsidize the employer's participation in a supported employment program;
- b. Payments that are passed through to individuals receiving supported employment; or
- c. Payments for vocational training that are not directly related to an individual's supported employment program.

Supported Employment Services consist of two components: job finding and job support. Job finding may include interview assistance, employer outreach and orientation, resume preparation, job searching, and preparation for job tasks. Other examples of activities that may be associated with job finding include participation in individual planning for employment; development of job seeking skills; development of customer-specific job skills; job analysis; support to learn job tasks; consultation with the Office of Vocational Rehabilitation (OVR), benefits counseling agencies, and provider networks under Ticket to Work on behalf of an individual; assistance in beginning a business; and outreach with prospective employers on behalf of the individual including consultation on tax advantages and other benefits.

Job support consists of training individuals in job assignments, periodic follow-up and/or ongoing support with individuals and their employers. The service must be necessary for individuals to maintain acceptable job performance and work habits including assistance in learning new work assignments, maintaining job skills, and achieving performance expectations of the employer. Other examples of activities that may be associated with job support include participation in individual planning for employment, direct intervention with an employer, employment related personal skills instruction, support to relearn job tasks, training to assist individuals in using transportation to and from work, maintenance of appropriate work and interpersonal behaviors on the job, follow-along services at the work site after OVR funded services are discontinued, and technical assistance and instruction for the individual's co-workers that will enable peer support.

Ongoing use of the service is limited to support for individuals that cannot be provided by the employer through regular supervisory channels and/or on-the-job resources that are available to employees who are non-disabled. The provision of job finding services must be evaluated at least once every six calendar months by the ISP team, to assess whether the service is assisting the individual with the outcome of finding community employment. If the service is not assisting the individual with this outcome, the ISP team must identify changes to the Supported Employment service to realize this outcome or other service options to meet the individual's needs. The provision of job support services must be evaluated at least annually, as part of the ISP process, to determine whether the individual continues to require the current level of authorized services. The ISP must be updated, if necessary, to reflect the team's determination.

The service may be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported

Employment.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

This service may not occur in a Title 55, Chapter 2390 (licensed prevocational) facility or setting.

Supported Employment Services rendered under the waiver may not be available under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA. Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment - Job Finding and Job Support

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

1. 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the individual agrees to carry out supported employment responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the employment service
7. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Job Finding and Job Support

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the employment service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the staff agrees to carry out supported employment responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Supports Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition (Scope):

Supports Coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for waiver participants. Locating services and supports consists of assistance to the participant and his or her family in linking, arranging for, and obtaining services specified in an Individual Support Plan (ISP), including needed medical, social, habilitation, education, or other needed community services. Activities included under the locating function include all of the following, in addition to the documentation of activities:

- Participate in the ODP standardized needs assessment process to inform development of the ISP, including any necessary ISP updates;
- Facilitate the completion of additional assessments, based on participants' unique strengths and needs, for planning purposes and ISP development in order to address all areas of needs and the participant's strengths and preferences;
- Coordinate the development of the ISP;
- Assist the participant in identifying people to serve as part of the ISP team, and offer support to invite other people who may contribute valuable information during the planning process;
- Assist the participant and his or her family in identifying and choosing willing and qualified providers;
- Inform participants about unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the ISP;
- Provide information to participants on fair hearing rights and assist with fair hearing requests when needed and upon request; and
- Assist participants in gaining access to needed services and entitlements, and to exercise civil rights.

Coordinating consists of development and ongoing management of the ISP in cooperation with the participant, his or her family, members of the ISP team, and providers of service. Activities included under the coordinating function include all of the following, in addition to the documentation of activities:

- Use a person centered planning approach and a team process to develop the participant's ISP to meet the participant's needs in the least restrictive manner possible;
- Use information from the ODP standardized needs assessment, as well as any additional assessments completed based on the unique needs of the participant, to develop the ISP to address all of the participant's needs;
- Periodic review of the ISP with the participant, including update of the ISP at least annually and whenever a participant's needs change;
- Periodic review of the standardized needs assessment through a face-to-face visit with the participant, at least annually or more frequently based on changes in a participant's needs, to ensure the assessment is current;
- Coordinate support planning with providers of service to ensure consistency of services;
- Coordinate with other program areas as necessary to ensure all areas of the participant's needs are addressed;
- Contact with family, friends, and other community members to coordinate the participant's natural support network;
- Facilitate the resolution of barriers to service delivery and civil rights; and
- Disseminate information and support to participants and others who are responsible for planning and implementation of services.

Monitoring consists of ongoing contact with the participant and their family, and oversight, to ensure services are implemented as per the participant's plan. Activities included under the monitoring function include all of the following, in addition to the documentation of activities:

- Monitor the health and welfare of participants through regular contacts at the minimum frequency outlined in Appendix D-2-a of this Waiver;
- Monitor ISP implementation through monitoring visits with the participant, at the minimum frequency outlined in Appendix D-2-a of this Waiver;
- Visit with the participant's family, when applicable, and providers of service for monitoring of health and welfare and support plan implementation;
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of participants;
- Evaluate participant progress;
- Monitor participant and/or family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary to address the needs of the participant, and modify the ISP accordingly;
- Ensure that services are appropriately documented in HCSIS on the ISP;
- Work with the authorizing entity regarding the authorization of services;

- Communicate the authorization status to ISP team members, as appropriate;
- Validate that service objectives and outcomes are consistent with the participant’s needs and desired outcomes;
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and participant rights; and
- Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the participant, preparing survey information, and follow up activities (“closing the loop”).

In addition to locating, coordinating, and monitoring, Supports Coordination also includes providing information and assistance in order to help participants decide whether to select participant direction of services, and assistance for participants who opt to direct services. Activities include all of the following, in addition to the documentation of activities:

- Provide participants with information on participant direction, including the potential benefits and risks associated with directing services, during the planning process and upon request;
- Assist with the transition to the participant direction service delivery model if the participant is interested in this model, and ensure continuity of services during transition;
- Assist the participant in designating a surrogate, as desired, as outlined in Appendix E-1-f of this Waiver; and
- Provide support to participants who are directing their services, such as assistance with managing participant-directed services specified in the ISP.

The following activities are excluded from Supports Coordination as a billable Waiver service:

- Outreach that occurs before an individual is enrolled in the Waiver;
- Intake for purposes of determining whether an individual has mental retardation and qualifies for Medical Assistance;
- Direct Prevention Services, which are used to reduce the probability of the occurrence of mental retardation resulting from social, emotional, intellectual, or biological disorders;
- General information to participants, families, and the public that is not on behalf of a waiver participant;
- Travel expenses of the Supports Coordinator may not be billed as a discrete unit of service;
- Services otherwise available under Medicaid and Early Intervention;
- Services that constitute the administration of foster care programs;
- Services that constitute the administration of another non-medical program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, and special education;
- Direct delivery of medical, educational, social, or other services
- Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;
- The actual cost of the direct services other than Supports Coordination that the Supports Coordinator links, arranges, or obtains on behalf of the participant;
- Transportation provided to participants to gain access to medical appointments or direct Waiver services other than Supports Coordination;
- Representative payee functions;
- Conducting Medicaid eligibility certification or recertification, intake processing, Medicaid pre-admission screening for inpatient care, prior authorization for Medicaid services, and Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system); and
- Assistance in locating and/or coordinating burial or other services for a deceased participant.

Supports Coordination services may not duplicate other direct Waiver services.

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP’s travel policy.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Supports Coordination service is limited to 300 units per participant per fiscal year. This limit may be waived based on the unique needs of a participant, with written approval from the ODP Regional Office.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supports Coordination Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:

Agency

Provider Type:

Supports Coordination Organization

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Minimum Qualifications of Supports Coordination Organizations:

1. Is in compliance with 55 PA Code Chapter 6201.12 (b)(3), (5), (6), (7), and (10)(ii), (iii), and (iv).
2. Function as a conflict free entity. A conflict-free Supports Coordination Organization, for purposes of this service definition, is an independent, separate, or self-contained agency. To be conflict free, an Organization may not provide direct services to individuals with mental retardation. The following are direct services:
 - a. All licensed and unlicensed Mental Retardation residential services provided to individuals with mental retardation;
 - b. All non-residential services provided to individuals with mental retardation, except Supports Coordination and Targeted Service Management, and the administration of Family Driven Support Service funds;
 - c. All services, provided under the Consolidated and Person/Family Directed Support Waivers, to individuals with mental retardation, with the exception of Supports Coordination; and
 - d. All services related to Health Care Quality Units, Independent Monitoring Teams, Intermediary Service Organizations for Waiver participants, and the Statewide Needs Assessment.
3. Board composition may only include a maximum of 25% of members who may have a formal relationship with a direct provider of Consolidated, P/FDS, or MR Base Services other than Supports Coordination or TSM.
4. Has at least one key management or executive personnel who qualify as a Qualified Mental Retardation Professional.
5. Utilizes a 24-hour response system that ensures access to organization personnel for response to emergency situations.
6. Conducts a standard ODP customer satisfaction survey with a representative sample of participants as specified by ODP and takes corrective action based on results.
7. Has an agreement with the local intake entity to ensure consistent referrals of eligible individuals and a smooth transition to the Supports Coordination Organization, unless this function is provided by a unit of the Supports Coordination Organization as a non-covered service.
8. Has a signed Medical Assistance Provider Agreement with ODP.
9. Meets the requirements for operating a not-for-profit, profit, or governmental organization in Pennsylvania.
10. Has Commercial General Liability Insurance
11. Has Professional Liability Errors and Omissions Insurance
12. Automobile insurance for all automobiles owned, leased, and/or hired as a component of the Supports Coordination service
13. Has Workers' Compensation Insurance, when required by Pennsylvania statute
14. Has a process for utilizing the Home and Community Services Information System (HCSIS) to document and perform Supports Coordination activities.
15. Agrees to enter and update provider-related information in HCSIS and PROMISE for the Supports Coordination Organization.
16. Agrees to comply with rate setting and billing requirements for Supports Coordination services, which includes utilizing a process for reconciliation of claims and rebilling.

17. Accepts the current Supports Coordination reimbursement rate as payment in full, and will not charge the individual or any other public funding source for Supports Coordination services.
18. Has a signed standard Waiver Provider Contract with the applicable Administrative Entity(ies) until June 30, 2009 as per the current AE Operating Agreement.
19. Complies with HIPAA.
20. Cooperates with provider monitoring conducted by the applicable Administrative Entity(ies) or ODP or its agents.
21. Cooperates with and assists, as needed, ODP and any state and federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting Medicaid fraud and abuse.
22. Has a process to review the utilization of Supports Coordination services.
23. Has a Quality Management strategy consistent with the approved waiver.
24. Complies with the ODP Incident Management policy.
25. Complies with all applicable ODP policy bulletins.
26. Agrees to immediately notify the applicable administrative entity(ies) and ODP in writing of any noncompliance or failure to meet any of these qualification criteria.
27. Cooperates with Health Care Quality Units, independent monitoring teams, and other external monitoring conducted by ODP business agents.
28. Agrees to commit to transition planning in the event of termination by the Supports Coordination Organization or termination of qualification by ODP.

Minimum Qualifications for Supports Coordinators who provide services through a Supports Coordination Organization:

1. Effective July 1, 2008, New Supports Coordinators receive ODP-required orientation.
 2. Effective January 1, 2008, Supports Coordinators and Supports Coordinator Supervisors with a caseload receive a minimum of 40 hours of training each calendar year, comprised of the required annual ODP-sponsored training sessions and local training.
 3. Effective January 1, 2008, Supports Coordinator Supervisors without a caseload receive the required annual ODP-sponsored training.
 4. Supports Coordinators conduct monitoring at the minimum frequency requirements outlined in D-2-a of this Waiver.
 5. Supports Coordinators and Supports Coordinator Supervisors with a caseload meet the following minimum requirements:
 - a. Have criminal background check that complies with 6 Pa Code Chapter 15;
 - b. Have child abuse clearances under Act 33 and Act 73; and
 - c. Meet the following minimum educational and experience requirements:
 - i. A bachelor's degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or
 - ii. Two years experience as a County Social Service Aide 3* and two years of college level course work, which include at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service; or
 - iii. Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.
- *The nature of the work and job requirements for County Social Service Aide 3 positions can be found at www.scsc.state.pa.us.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Developmental Programs

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

49 Pa.Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP's travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Nursing services must be prior authorized as a needed service by ODP in order to be eligible through the waiver. Prior authorization will be made considering the individual's needs assessment results, other appropriate medical professional assessments, and based on the following medical needs:

- Full- or part-time dependent on a ventilator
- Tracheostomy care for a critical or non-critical airway
- Flushing, hanging medications, providing total parenteral nutrition, trouble shooting central and peripheral lines
- Diminished lung capacity
- Medication administration in nine and ten person licensed homes
- Medication administration or treatments when injections or treatments are necessary only when no other paid or unpaid person is trained and available

Services may only be funded through the waiver if they are not available through Medical Assistance, Medicare and/or private insurance. Services will be provided under the State plan and/or private insurance plans until the plan limitations have been reached.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nurse
Agency	Nursing Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Individual

Provider Type:

Nurse

Provider Qualifications

License (specify):

Registered Nurse (RN)

Licensed Practical Nurse (LPN)

Title 49 Pa. Code Chapter 21 or comparable regulations for providers based in states other than Pennsylvania

Certificate (specify):

Other Standard (specify):

1. Licensing requirements as per 'License' above
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Workers' Compensation Insurance, when required by Pennsylvania statute
5. Documentation that the individual agrees to carry out nursing responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Nursing Agency

Provider Qualifications

License (specify):

Registered Nurse (RN)

Licensed Practical Nurse (LPN)

Title 49 Pa. Code Chapter 21 or comparable regulations for providers based in states other than Pennsylvania

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Nurses working for agencies must meet the following standards:

1. Meet licensing requirements as per 'License' above
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out nursing responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Therapy Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Therapy services include the following:

- Physical therapy provided by a licensed physical therapist based on a prescription for a specific therapy program by a physician, or recommendation by a physical therapist.
- Occupational therapy by a registered occupational therapist based on a prescription for a specific therapy program by a physician, or recommendation by an occupational therapist.
- Speech/language therapy provided by an ASHA certified and state licensed speech-language pathologist upon examination and recommendation by an ASHA certified and state licensed speech-language pathologist or a physician.
- Visual/mobility therapy provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.
- Behavior therapy provided by a licensed psychologist or psychiatrist based on an evaluation and recommendation by a licensed psychologist or psychiatrist.

Therapy services are direct services provided to assist individuals in the acquisition, retention, or improvement of skills necessary for the individual to live and work in the community, and must be attached to an individualized outcome. The need for the service must be evaluated on a periodic basis, at least annually as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services and that the service continues to result in positive outcomes for the individual. It is recognized, however, that long-term Therapy services may be necessary due to an individual's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the individual's ISP.

Physical Therapy: The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "...means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

Occupational Therapy: The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1)

Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

Speech and Language Therapy: Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech-language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

Behavior Therapy: The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist deliberately establishes a professional relationship with an individual, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy may take the form of individual therapy with the individual and the psychologist or psychiatrist, or in a group setting supervised and directed by the psychologist or psychiatrist.

Visual/Mobility Therapy: This therapy is for individuals who are blind or have visual impairments. The provision of therapy is for the purpose of increasing individuals' travel skills and/or access to items used in activities of daily living.

This service may include evaluation and assessment of individuals and the environments in which they interact, direct service (face-to-face) to individuals, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP's travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services may only be funded through the waiver if they are not available through Medical Assistance, Medicare and/or private insurance. Services will be provided under the State plan and/or private insurance plans until the plan limitations have been reached.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Therapy Agency
Agency	Speech/Language Therapy Agency
Agency	Visual/Mobility Therapy Agency
Agency	Occupational Therapy Agency
Agency	Physical Therapy Agency
Individual	Behavior Therapist
Individual	Speech/Language Therapist
Individual	Occupational Therapist
Individual	Visual/Mobility Therapist
Individual	Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Behavior Therapy Agency

Provider Qualifications

License (specify):

Psychologist

Psychiatrist

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Therapists working for agencies must meet the following standards:

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Speech/Language Therapy Agency

Provider Qualifications

License (specify):

State licensed speech-language pathologist

Certificate (specify):

ASHA certified

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Therapists working for agencies must meet the following standards:

1. Licensing and certification requirements specified in 'License' and 'Certificate' above.

2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Visual/Mobility Therapy Agency

Provider Qualifications

License (specify):

Certificate (specify):

Trained visual or mobility specialist/instructor

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Therapists working for agencies must meet the following standards:

1. Certification requirements specified in 'Certificate' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Occupational Therapy Agency

Provider Qualifications

License (specify):

Occupational Therapist

Certificate (specify):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Therapists working for agencies must meet the following standards:

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Physical Therapy Agency

Provider Qualifications

License (*specify*):

Physical therapist

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Workers' Compensation Insurance, when required by Pennsylvania statute

Therapists working for agencies must meet the following standards:

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

Behavior Therapist

Provider Qualifications

License (specify):

Psychologist

Psychiatrist

Certificate (specify):

Other Standard (specify):

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

Speech/Language Therapist

Provider Qualifications

License (specify):

State licensed speech-language pathologist

Certificate (specify):

ASHA certified

Other Standard (specify):

1. Licensing and certification requirements specified in 'License' and 'Certificate' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual ▾

Provider Type:

Occupational Therapist

Provider Qualifications

License (*specify*):

Occupational Therapist

Certificate (*specify*):

Other Standard (*specify*):

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual ▾

Provider Type:

Visual/Mobility Therapist

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Trained visual or mobility specialist/instructor

Other Standard (*specify*):

1. Certification requirements specified in 'Certificate' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual ▾

Provider Type:

Physical Therapist

Provider Qualifications

License (specify):

Physical therapist

Certificate (specify):

Other Standard (specify):

1. Licensing requirements specified in 'License' above.
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out therapy responsibilities based on the individual's support plan
5. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Supports Broker Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This is a direct (face-to-face) and indirect service to individuals with mental retardation in arranging for, developing, and managing the services they are self-directing through either employer authority (hiring/managing workers) or budget authority (determining worker salaries, shifting funds between approved services and/or providers). Services are provided to assist individuals in identifying immediate and long-term needs, developing community-based options to meet those needs, and accessing identified supports and services. Services also involve practical skills training and information for individuals and surrogates related to directing and managing services. This service is limited to:

- Assistance in identifying and sustaining a personal support network of family, friends, and associates to meet individual needs;
- Assistance in arranging for and effectively managing generic community resources and informal supports to meet individual needs;
- Assistance at planning meetings to ensure the individual's access to needed quality community resources;
- In depth practical skills training for individuals and surrogates related to self-direction and management of qualified support service workers. Training is limited to employer responsibilities (e.g. hiring, managing, and terminating workers; reviewing and approving timesheets; problem solving; conflict resolution);

- Assistance to the individual in managing, monitoring, and reviewing their participant directed budget;
- Development of back-up plans in the event of emergencies and/or unexpected worker absences;
- Training to the individual to help them recognize reportable incidents and help them report the incidents to the Supports Coordinator or provider as required;
- Assistance with paperwork related to the individual’s employer responsibilities as the employer of record or co-employer of support service workers;
- Assistance with budgeting, including review and evaluation of monthly expenditure reports; and
- Providing detailed information and training to individuals about: person centered planning and how it is applied, risks and responsibilities related to self-direction, free choice of willing and qualified providers, individual rights, and use of community and natural supports.

Supports brokers must work collaboratively with the individual’s supports coordinator. The role of the Supports Coordinator continues to involve the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists individuals and families with being able to self-direct their support. It is important to understand that each role is vital to the support of the individual and their family. It is also important to understand that Supports Coordinators also assist individuals and families with self-directing their support, however, not necessarily at the level of intensity that is needed by many.

Supports Broker Services are different from Supports Coordination and Supports Brokers may not replace the role or perform the functions of a Supports Coordinator; no duplicate payments will be made.

Supports Broker Services may not be provided by agency providers that provide other direct Waiver services or administrative services (for example, a Health Care Quality Unit, an Independent Monitoring Program, or an Intermediary Service Organization).

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP’s travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year. This service is limited to individuals who are self-directing their services through employer and/or budget authority.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Supports Broker
Agency	Supports Brokerage Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Supports Broker Services

Provider Category:

Individual ▼

Provider Type:

Supports Broker

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on the participant's ISP
3. Documentation that the individual agrees to carry out the supports broker responsibilities based on the ISP
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Auto insurance for all vehicles owned, leased, and/or hired as a component of the supports broker service
7. Workers compensation insurance, when required by PA statute
8. Training in basic employment law, one year of experience working in human resources, one year of experience in a management position with human resource responsibilities, or a degree in human services
9. Training on the principles of self-determination
10. Training on participant directed services
11. If assisting in planning meetings, training on person centered thinking

Verification of Provider Qualifications**Entity Responsible for Verification:**

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Supports Broker Services****Provider Category:**Agency **Provider Type:**

Supports Brokerage Agency

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

The Supports Broker agency must meet the following requirements:

1. Auto insurance for all vehicles owned, leased, and/or hired as a component of the supports broker service
2. Workers compensation insurance, when required by PA statute
3. Commercial General Liability Insurance
4. Professional Liability Errors and Omissions Insurance
5. Supports Broker Services may not be provided by agency providers that provide other direct Waiver services or administrative services (for example, a Health Care Quality Unit, an Independent Monitoring Program, a Financial Management Organization, an Administrative Entity, or a County Program).

Supports brokers working for the agency must meet the following requirements:

1. Be at least 18 years of age
2. Complete of necessary pre/in-service training based on the participant's ISP
3. Documentation that the individual agrees to carry out the supports broker responsibilities based on the ISP
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Meet the following minimum requirements:

- a. Be trained in basic employment law,
- b. Have one year of experience working in human resources,
- c. Have one year of experience in a management position with human resource responsibilities, OR
- d. Have a degree in human resources
- 7. Be trained on the principles of self-determination
- 8. Be trained on participant directed services
- 9. If assisting in planning meetings, be trained on person centered thinking

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve an individual’s functioning.

Assistive technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device, limited to:

- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the individual;
- Selecting, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;
- Training for the individual, or, where appropriate, the individual’s family members, guardian, advocate, staff, or authorized representative on how to use and/or care for the assistive technology;
- Extended warranties; and
- Ancillary supplies, software, and equipment necessary to the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices.

Please note that repair and maintenance of devices and purchases of extended warranties are limited to those devices purchased through the Waivers.

All items shall meet the applicable standards of manufacture, design, and installation. Items shall be specific to the individual’s needs and not be approved to benefit the public at large, staff, significant others, or family members. Items reimbursed with waiver funds shall be in addition to any medical supplies provided under the Medicaid state plan and shall exclude those items not of direct medical or remedial benefit to the individual. If the participant receives Behavioral Therapy or Behavioral Support Services, the assistive technology must be consistent with the individual’s behavioral support plan.

Assistive technology devices must be recommended by an independent evaluation of the individual's assistive technology needs. The organization or professional providing the evaluation shall be credentialed, licensed, or certified in an area related to the specific type of technology needed, and may not have a fiduciary relationship with the assistive technology provider.

The service may be provided by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services may only be funded through the waiver if they are not available through Medical Assistance, Medicare and/or private insurance. Services will be provided under the State plan and/or private insurance plans until the plan limitations have been reached.

Durable medical equipment, as defined by Title 55 PA Code Chapter 1123 and the Medical Assistance State Plan, is excluded.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Adherence to all applicable local and state codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. Adherence to all applicable local and state codes
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This is a service that includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, parents and caretakers. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

The service is performed under the supervision of a professional who is licensed or has a Masters or Doctorate Degree in Human Services (or a closely related field), and is limited to the following:

- Collection and evaluation of behavioral data;
- Observation of the participant in various settings for the purpose of developing a behavior support plan;
- Collaboration with the participant, their family, and their team for the purpose of developing a behavior support plan that must include positive practices and may not include restraint procedures (physical, chemical, or mechanical) as support strategies;
- Conducting comprehensive functional assessments of presenting issues (e.g. aggression, self-injurious behavior, law offending behavior (sexual or otherwise));

- Development and maintenance of behavior support plans, which utilize positive strategies to support the participant, based on functional behavioral assessments;
- Conducting training related to the implementation of behavior support plans for the participant, family members, and staff;
- Implementation of activities and strategies identified in the participant’s behavior support plan;
- Monitoring implementation of the behavior support plan, and revising as needed;
- Collaboration with the participant, their family, and their team in order to develop positive interventions to address specific presenting issues; and
- Completion of required paperwork related to data collection, progress reporting and development of annual planning material.

Services may be provided in the office of the Behavioral Support professional, the individual’s home or service location, or in local public community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis.

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP’s travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Behavioral Support services may be provided during the same day and time as other waiver services, but may not duplicate other waiver services.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Support Specialist
Agency	Behavior Support Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Individual

Provider Type:

Behavior Support Specialist

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on the participant’s ISP
3. Documentation that the individual agrees to carry out the behavior support responsibilities based on the ISP
4. Criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Child Abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

6. Auto insurance for all vehicles owned, leased, and/or hired as a component of the behavior support service
7. Workers compensation insurance, when required by PA statute
8. Complete training in conducting and using a Functional Behavioral Assessment.
9. Complete training in positive behavioral support.
10. Have at least 2 years experience in working with people with mental retardation.
11. Work under the supervision of a professional who is licensed or has a Masters or Doctorate Degree in Human Services (or a closely related field).

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavioral Support

Provider Category:

Agency

Provider Type:

Behavior Support Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Behavioral Support agency must meet the following requirements:

1. Auto insurance for all vehicles owned, leased, and/or hired as a component of the behavior support service
2. Workers compensation insurance, when required by PA statute
3. Commercial General Liability Insurance
4. Professional Liability Errors and Omissions Insurance

Behavior support staff working for the agency must meet the following requirements:

1. Be at least 18 years of age
2. Complete of necessary pre/in-service training based on the participant's ISP
3. Documentation that the staff agrees to carry out the behavior support responsibilities based on the ISP
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Complete training in conducting and using a Functional Behavioral Assessment.
7. Complete training in positive behavioral support.
8. Have at least 2 years experience in working with people with mental retardation.
9. Work under the supervision of a professional who is licensed or has a Masters or Doctorate Degree in Human Services (or a closely related field).

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Companion services are provided to individuals living in private residences for the limited purposes of providing supervision and minimal assistance that is focused solely on the health and safety of the adult individual with mental retardation. This service is not available to people who are residing in Unlicensed or Licensed Residential Habilitation settings. Companion services are used in lieu of habilitation services to protect the health and welfare of the individual when a habilitative outcome is not appropriate or feasible (i.e. when the individual is not learning, enhancing, or maintaining a skill). This service can be used for asleep hours when only supervision or non-medical or non-habilitative care is needed to protect the safety of the individual with mental retardation. For example, a companion can be used during overnight hours for an individual who lives on their own but does not have the ability to safely evacuate in the event of an emergency. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety. Companions may supervise and provide minimal assistance with daily living activities, including grooming, health care, household care, meal preparation and planning, and socialization. This service may not be provided at the same time as any other service.

This service may be provided at the following levels:

- Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:6.
- Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.
- Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.
- Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP's travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not available for participants residing in agency-owned, rented/leased, or operated homes.

Companion and Home and Community Habilitation (Unlicensed) Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Companion

Agency

Companion Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Companion

Provider Category:

Individual

Provider Type:

Individual Companion

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the individual agrees to carry out companion responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the companion service
7. Workers' Compensation Insurance, when required by Pennsylvania statute

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Companion

Provider Category:

Agency

Provider Type:

Companion Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the companion service

4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for the agency must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the staff agrees to carry out companion responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Home accessibility adaptations consist of certain modifications to the private home of the individual (including homes owned or leased by parents/relatives with which the individual resides) which are necessary due to the individual's disability, to ensure the health, security, and accessibility of the individual, or which enable the individual to function with greater independence in the home. This service may only be used to adapt the individual's primary residence, may not be furnished to adapt homes that are owned or leased by providers.

Home modifications must have utility primarily for the individual with the disability, be an item of modification that the family would not be expected to provide to a family member without a disability, be an item that is not part of general maintenance of the home, and be an item or modification that is not part of room and board costs as defined in 55 Pa.Code Chapter 6200. Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition. Adaptations that add to the total square footage of the home are excluded from this benefit. The only exception to this is adaptations to bathrooms that are necessary to complete the adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair). Durable medical equipment is excluded.

All modifications shall meet the applicable standards of manufacture, design, and installation. Modifications shall be specific to the individual's needs and not be approved to benefit the public at large, staff, significant others, or family members; modifications or improvements to the home that are of general utility are excluded. Modifications not of direct medical or remedial benefit to the individual are excluded.

Modifications to a household subject to funding under the waivers are limited to the following:

- Ramps from street, sidewalk or house.
- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a “track” in the ceiling for moving an individual with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home or other surroundings
- Outside railing from street to home.
- Widened doorways, landings, and hallways.
- An additional doorway needed to ensure the safe egress of the individual during emergencies, when approved by the ODP Regional Office.
- Swing clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Plexiglas windows for individuals with behavioral issues as noted in the individual’s ISP.
- Slip resistant flooring.
- Kitchen counter, major appliance, sink and other cabinet modifications.
- Bathroom modifications for bathing, showering, toileting and personal care needs.
- Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Workroom modifications to desks and other working areas.

All adaptations to the household shall be provided in accordance with applicable building codes.

The service may be provided by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum state and federal funding participation is limited to \$20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new \$20,000 limit can be applied when the individual moves to a new home. The 10 year period begins at the first utilization of authorized Home Accessibility Adaptations. In situations of joint custody (as determined by an official court order) or other situations where an individual divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of \$20,000 for this service.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Contractor's license for state of PA or comparable license for providers based in states contiguous to Pennsylvania

Certificate (specify):

Other Standard (specify):

1. Adherence to all applicable local and state codes
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Contractor's license for state of PA or comparable license for providers based in states contiguous to Pennsylvania

Certificate (specify):

Other Standard (specify):

Adherence to all applicable local and state codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Finding

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Direct services provided to assist individuals to locate and maintain a home of their own. Services are limited to assistance in financial planning, arranging for or moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, assistance in making monthly payments, and assistance in purchasing home security devices, such as beepers or alarms which are necessary to ensure the individual's health and well-being.

Financial support that constitutes a room and board expense is excluded from federal financial participation in the waivers.

The service may be provided by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Finding Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Finding

Provider Category:

Agency

Provider Type:

Home Finding Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the home finding

service

4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the staff agrees to carry out home finding responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
6. Documentation that the staff will not benefit financially through the delivery of the service

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Finding

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on individual support plan.
3. Documentation that the individual agrees to carry out home finding responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
5. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the home finding service
6. Workers' Compensation Insurance, when required by Pennsylvania statute
7. Documentation that the staff will not benefit financially through the delivery of the service

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Specialized Supplies consist of incontinence supplies that are not available through the State Plan or private insurance. Supplies are limited to adult diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves.

This service may be provided in Pennsylvania, or anywhere in the United States, during temporary travel as per ODP’s travel policy. The service may also be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to \$500 per individual per fiscal year.

Services may only be funded through the waiver if they are not available through Medical Assistance, Medicare and/or private insurance. Services will be provided under the State plan and/or private insurance plans until the plan limitations have been reached.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Supplies

Provider Category:

Agency

Provider Type:

Supplier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Adherence to all applicable local and state codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Work Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Transitional Work Services consist of supporting individuals in transition to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 Pa.Code Chapter 2380 or Chapter 2390 regulations. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave. A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrates job expertise and meets established production rates. Affirmative Industry is operated as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business. Enclave is a business model where disabled individuals are employed by a business/industry to perform specific job functions while working alongside non-disabled workers.

Agency-based providers of Transitional Work Services may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does not include transportation to and from the individual's home (including licensed and unlicensed residential settings) and the day service. Transportation included in the rate for Transitional Work Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

This service may be provided at the following levels:

- Basic Staff Support - The provision of the service at a staff-to-individual ratio of 1:10 to >1:6.
- Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.
- Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.
- Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

The service may be provided on an ongoing basis by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not be funded through the waiver if it is available to individuals under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17) of IDEA. Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transitional Work Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the transitional work service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for agencies must meet the following standards:

1. At least 18 years of age
2. Completion of necessary pre/in-service training based on Individual support plan.
3. Documentation that the staff agrees to carry out transitional work responsibilities based on the individual's support plan.
4. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15

5. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Transportation Services are offered in order to enable individuals receiving services to gain access to waiver and other community services and resources specified in the individual plan. Transportation services consist of:

1. Transportation (Mile): Reimbursement for mileage to providers, family members and other licensed drivers for using vehicles to transport the individual to services specified in the individual's support plan. The reimbursement does not exceed the reimbursement rate established for Department of Public Welfare employees for such purposes. Mileage reimbursement to providers is limited to situations where transportation costs are not included in the provider's rate for services.
2. Transportation (Trip): Transportation for which costs are determined on a per trip basis. A trip is either transportation to a waiver service from the participant's home or from the waiver service to the participant's home. Taking a participant to a waiver service and returning the participant to his/her home is considered two trips or two units of service.
3. Transportation (per diem): Transportation provided by provider agencies for non-emergency purposes that is reimbursed on a per diem basis.
4. Public Transportation: Public transportation for individuals enabling access to services/resources in accordance with their ISPs.

Transportation included in the rate for agency-based Unlicensed Home and Community Habilitation, Residential Habilitation, Prevocational Services, Day Habilitation, or Transitional Work Services may NOT be duplicated through the inclusion of the discrete transportation service on an individual's ISP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual, Non-Relative/Non-Legal Guardian
Individual	Relative/Legal Guardian
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual, Non-Relative/Non-Legal Guardian

Provider Qualifications

License (specify):

Valid Pennsylvania driver's license

Certificate (specify):

-Current State motor vehicle registration

-PUC Certification, when required by Pennsylvania law

Other Standard (specify):

1. At least 18 years of age

2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15

3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63

4. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the transportation service

5. Workers' Compensation Insurance, when required by Pennsylvania statute

6. Documentation that the individual agrees to carry out transportation responsibilities based on the individual's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Relative/Legal Guardian

Provider Qualifications

License (*specify*):

Valid Pennsylvania driver’s license

Certificate (*specify*):

Current State motor vehicle registration

PUC Certification, when required by Pennsylvania law

Other Standard (*specify*):

1. At least 18 years of age
2. Automobile insurance coverage as required by the State Department of Transportation
3. Documentation that the relative/legal guardian agrees to carry out transportation responsibilities based on the individual’s support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

Valid Pennsylvania driver’s license

Certificate (*specify*):

-Current State motor vehicle registration

-PUC Certification, when required by Pennsylvania law

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Professional Liability Errors and Omissions Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the transportation service
4. Workers’ Compensation Insurance, when required by Pennsylvania statute

Drivers working for agencies must meet the following standards:

1. At least 18 years of age
2. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
3. Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63
4. Documentation that the staff agrees to carry out transportation responsibilities based on the individual’s support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Entity

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Vehicle accessibility adaptations consist of certain modifications to the vehicle of the individual (including a vehicle owned by parents/relatives/legal guardians with which the individual resides) which are necessary due to the individual’s disability. Vehicle modifications consist of installation, repair, maintenance, and extended warranties for the modifications. Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, except for upkeep and maintenance of the modifications, is excluded.

The waiver cannot be used to purchase vehicles for waiver recipients, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

These adaptations funded through the waivers are limited to the following:

- Vehicular lifts.
- Interior alterations to seats, head and leg rests, and belts.
- Customized devices necessary for the individual to be transported safely in the community, including driver control devices.
- Raising the roof or lowering the floor to accommodate wheelchairs.

The service may be provided by qualified providers based in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum state and federal funding participation is limited to \$10,000 per individual during a 5-year period. The 5-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Adherence to all applicable local and state codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. Adherence to all applicable local and state codes
2. Commercial General Liability Insurance
3. Professional Liability Errors and Omissions Insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Not applicable

Frequency of Verification:

Not applicable

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

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

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies
 - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
 - As an administrative activity.** Complete item C-1-c.
- None of the above apply** (i.e., case management is furnished as a waiver service)

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

ODP requires criminal background checks for all employees/workers that come in contact with any waiver participant, and child abuse clearances on all employees that come in contact with waiver participants who are under the age of 18. Specific requirements for criminal background checks are included in 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15 (Older Adult Protective Services Act, OAPSA). OAPSA states that applicants must submit with their applications a report of criminal history record information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. If the applicant has not been a resident of the Commonwealth for the two years immediately preceding the date of application, the facility shall require the applicant to submit with the application for employment a report of Federal criminal history record from the Federal Bureau of Investigation (FBI) in addition to a criminal history record from the State Police. An applicant may not be hired, or employment must be terminated for convictions specified in OAPSA.

Compliance with background check requirements is verified through initial and annual provider qualification reviews, as well as provider monitoring conducted by AEs. For licensed providers (see regulatory language below), compliance with the Pennsylvania Code is verified through annual licensing inspections.

55 PA Code, Community Homes for Individuals with Mental Retardation (Criminal History Record Check) § 6400.21
 Pennsylvania Code requires that an application for a criminal history record check be submitted to the Pennsylvania State Police for employees of “the home” who will have direct contact with individuals, this includes part-time and temporary employees. This must be completed within five working days after the person’s date of hire. If the applicant has not been a resident of Pennsylvania for two years preceding the date of application, a criminal history record is required from the Federal Bureau of Investigation (FBI), in addition to the Pennsylvania criminal history record, also within five working days after the date of hire. Pennsylvania Code also states that criminal history checks shall have been completed no more than one year prior to the person’s date of hire.

55 PA Code, Family Living Homes (Criminal History Record Check) § 6500.23
 Pennsylvania Code (the Commonwealth's official publication of rules and regulations) requires that an application for a criminal history record check be submitted to the Pennsylvania State Police for “individuals 18 years of age or older who reside in the home, prior to an individual living or receiving respite care in the home.” If any person in the home whom is 18 years of age or older is not a resident of Pennsylvania, a criminal history record is required from the Federal Bureau of Investigation (FBI) prior

to an individual living or receiving respite care in the home. These requirements also apply to “any person 17 years of age or older who moves into the home and any person who reaches the age of 18 years, after the individual lives in the home. Pennsylvania Code also states that any criminal clearances would be completed no more than 1 year prior to an individual living or receiving respite care in the home.

55 PA Code, Adult Training Facilities (Criminal history record check) § 2380.20

Pennsylvania code requires that all prospective employees who will have direct contact with participants have a criminal history check submitted to the State Police within five (5) days of the employee's date of hire. If a prospective employee resides outside of Pennsylvania, a criminal record check must be submitted to the FBI in addition to the State Police within five (5) days after the employee's hire.

55 PA Code, Child Residential and Day Treatment Facilities (Child abuse and criminal history checks) § 3800.51

Pennsylvania code requires that child abuse and criminal history checks are completed in accordance with 23 Pa.C.S. § § 6301—6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type
Respite, 55 PA Chapters 6400 (Community Homes), 3800 (Child Residential Facilities), 5310 (Community Rehabilitative Residential Services)
Licensed Residential Habilitation, Title 55 Chapter 5310 (Community Rehabilitative Residential Services)
Licensed Residential Habilitation, Title 55 Chapter 6500 (Family Living Homes)
Licensed Residential Habilitation, Title 55 Chapter 3800 (Child Residential Facilities)
Licensed Residential Habilitation, Title 55 Chapter 6400 (Community Homes)

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

Larger facilities are licensed through regulation chapters that are based on the principle of normalization, which defines the right of the individual with mental retardation to live a life which is as close as possible in all aspects to the life which any member of the community might choose. The design of the service shall be made with the individual’s unique needs

in mind so that the service will facilitate the person’s ongoing growth and development. The home and service is also individualized to meet the needs of participants, as per their person-centered ISP. Regulatory requirements are verified through annual licensing inspections, while individualized services are monitoring through Supports Coordinators, Administrative Entities, and ODP through various oversight mechanisms.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Respite, 55 PA Chapters 6400 (Community Homes), 3800 (Child Residential Facilities), 5310 (Community Rehabilitative Residential Services)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

Facility Capacity Limit:

10 people if established prior to 01/01/1996; 4 people if established on or after 01/01/1996

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Residential Habilitation, Title 55 Chapter 5310 (Community Rehabilitative Residential Services)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>

Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

Facility Capacity Limit:

10 people if established prior to 01/01/1996; 4 people if established on or after 01/01/1996

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Residential Habilitation, Title 55 Chapter 6500 (Family Living Homes)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

Facility Capacity Limit:

2

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Residential Habilitation, Title 55 Chapter 3800 (Child Residential Facilities)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>

Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

Facility Capacity Limit:

10 people if established prior to 01/01/1996; 4 people if established on or after 01/01/1996

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Residential Habilitation, Title 55 Chapter 6400 (Community Homes)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

Facility Capacity Limit:

10 people if established prior to 01/01/1996; 4 people if established on or after 01/01/1996

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>

Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Legally responsible individuals may be paid to provide services funded through the Waivers on a service-by-service basis. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minors (natural or adoptive), spouses, and legally-assigned relative caregivers of minor children. These individuals may be paid to provide Waiver services when the following conditions are met:

- The service is considered extraordinary care, which means it is not part of the supports the legally responsible individual is ordinarily obligated to provide;
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver; and
- The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

Services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, Transportation (Mile), and Home Finding.

Payments to legally responsible individuals who provide services are made through a Financial Management Services (FMS) Organization, previously known as Intermediary Service Organizations (ISOs), or a provider agency. Payments are based upon time sheets submitted by the legally responsible individual to the FMS or agency, which are consistent with the individual's authorized services on their individual support plan. The AE and the FMS or agency is responsible to ensure that payments are only made for services that are authorized on the participant's approved ISP. The legally responsible individual who provides services must document those services as per bulletin 00-07-01, Provider Billing Documentation Requirements for Waiver Services (or any approved revisions).

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

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives/legal guardians may be paid to provide services funded through the Waivers on a service-by-service basis. A relative is any of the following who have not been assigned as legal guardian for the individual with mental retardation: a parent (natural or adoptive) of an adult, a stepparent of an adult child, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult child or stepchild of a parent with mental retardation, or adult grandchild of a grandparent with mental retardation. For the purposes of this policy, a legal guardian is a person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court). These individuals may be paid to provide Waiver services when the following conditions are met:

- The service provided is not a function that the relative or legal guardian would normally provide for the individual without charge in the usual relationship among members of a nuclear family;
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver; and
- The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

Services that relatives/legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, Transportation (Mile), and Home Finding. Relatives/legal guardians who are not the individual's primary caregiver may also provide Supports Broker Services and waiver-funded Respite Services when the conditions listed above are met.

Payments to relatives and legal guardians who provide services are made through a Financial Management Services (FMS) Organization, previously known as Intermediary Service Organizations (ISOs), or a provider agency. Payments are based upon time sheets submitted by the relative/legal guardian to the FMS or agency, which are consistent with the individual's authorized services on their individual support plan. The AE and the FMS or agency is responsible to ensure that payments are only made for services that are authorized on the participant's approved ISP. The relative or legal guardian who provides services must document those services as per bulletin 00-07-01, Provider Billing Documentation Requirements for Waiver Services (or any approved revisions).

- Other policy.**

Specify:

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

Providers interested in providing waiver services contact the AE or ODP to obtain information on provider qualification and enrollment, or are referred by waiver participants. ODP delegates the responsibility to determine whether interested providers meet waiver provider qualification criteria, as outlined in the approved Consolidated Waiver, to AE's. This excludes Supports Coordination providers, which are qualified by ODP. After the AE or ODP qualifies the provider, as per the qualification criteria outlined in Appendix C-3, the provider is able to enter service information into the ODP Services and Supports Directory and enter into a Medical Assistance Provider Agreement with ODP.

Waiver participants have free choice of willing and qualified waiver providers to provide needed services in the participant's approved ISP. If a provider is chosen by a waiver participant and is willing to serve the participant, the provider then enters into a standard waiver service contract with the AE (until June 30, 2009). Once selected, the contract will be executed and services will be delivered within forty-five (45) calendar days.

Additionally, ODP has implemented a provider dispute resolution protocol in which the Department is responsible to intervene in certain disputes between AE's and waiver providers. Waiver providers have the opportunity to submit a Provider Dispute Resolution request to the appropriate ODP Regional Office. If the dispute meets the criteria outlined in the current Provider Dispute Resolution Protocol, or any approved revisions made by the Department, ODP will complete a review of the dispute using the procedures outlined in the current Provider Dispute Resolution Protocol.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

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

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support Plan (ISP)

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

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker.**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

ODP has established a conflict-free policy for Supports Coordination providers through provider qualification criteria. Supports Coordination providers that currently provide other direct waiver services must submit a divestiture plan to ODP, as well as detailed information on the administrative procedures that are in place to ensure supports coordinators are free to identify problems with an individual's services, and that individuals have free choice of willing and qualified providers and of conflict-free supports coordination services pending divestiture. Plans are subject to approval by ODP.

The following are mechanisms that are in place to identify potential issues with ISP development by these AE's:

1. ODP maintains a log of all 888 calls and calls that come directly to its Regional offices. This log includes the funding stream and nature of the complaint and allows the ODP Regional Offices to conduct periodic reviews for any apparent trends that would relate to a lack of a conflict-free environment.
2. All ISP's for participants with a County AE are in HCSIS and can be reviewed by ODP. ODP completes regular reviews of ISP's (for both County AE's and non-governmental AE's) as part of the AE Oversight process. Additionally, the annual assessment, ISP outcomes, services notes, and ISP monitoring forms for participants with a County AE are available in HCSIS for review by ODP. ISP's, service notes, and ISP monitoring forms for participants with non-governmental AE's are available for review by ODP upon request.
3. The ODP Regional Offices review all incidents entered into HCSIS, as well as the outcomes of investigations. For AE's providing direct services, the ODP Regional Offices review for discrepancies between the outcomes of the investigations the AE performs on their own agencies and those of their contracted providers. Any questionable findings are researched further by the ODP Regional Office.
4. The Service Review process allows ODP to monitor/track review requests that identify the lack of provider choice as the issue for review.
5. IM4Q includes questions related to choice of providers, and ODP reviews this information through aggregate AE IM4Q reports.

In addition to the above oversight mechanisms, ODP reviews choice of provider through the AE Oversight process, which began in April 2007. AE Oversight includes indicators related to choice that will be used to identify potential conflict of interest issues.

Waiver participants and their families may access the ODP Services and Supports Directory (SSD), which is on the HCSIS homepage, to search for potential providers. The SSD provides the ability to search by geographical area, type of service, and provider name. Waiver participants without Internet access may ask their supports coordinator for assistance, may use a computer in the AE Office to use the SSD, or may ask their supports coordinator or AE for a printed copy of the SSD.

AE's are required to contract with any waiver provider that has a signed ODP Medical Assistance Agreement, if a waiver participant and/or their representative requests the services of such provider, if the provider agrees to serve the waiver participant, and if the provider costs for the service are consistent with efficiency, economy, and are adequate to provide quality of care as per the Administrative Entity Operating Agreement. Issues of noncompliance with the Agreement are addressed through the following remedies: Notification of the noncompliance in writing to the AE Administrator or Director, technical assistance, a required plan of correction, freeze of waiver enrollment by the AE pending an acceptable plan of correction, termination of the Agreement, or non-renewal of the Agreement.

Participants may appeal the denial of a qualified provider through the formal fair hearing process, and may also report issues regarding the selection of a qualified provider to their Supports Coordinator and Supports Coordination Entity, the Administrative Entity, or ODP through its Regional Offices or Customer Service Line (1-888-565-9435).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

(A) The Supports And Information That Are Made Available To The Participant (And/Or Family Or Legal Representative, As Appropriate) To Direct And Be Actively Engaged In The Service Plan Development Process

The Individual Support Plan (ISP) process involves collaboration between the individual, his or her family, friends, guardian, advocate, service provider and other people important in the individual's life via written correspondence, telephone conversations, and/or face-to-face meetings. The individual and his or her family drive the process if they choose to do so.

A key step in developing a meaningful ISP is to gather information that reflects the Everyday Lives Core Values. Information should be gathered from the person and those who know him or her best in order to gain and capture person centered information to determine the person's wants, preferences, strengths, and needs. If the person uses an alternate means of communication or if his or her primary language is not English, the information gathering process needs to utilize his or her primary means of communication, an interpreter, or someone who has a close enough relationship with the individual to accurately speak for him or her.

The individual and his or her family, friends, and team develop Outcome Summaries and Actions to support the attainment of what is important to and for the individual. After the development of Outcomes, services and supports are identified. When identifying services and supports, the individual, family and team considers all available resources, including natural supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations, and employers. ODP offers a set of services that can be utilized to support the person's needs.

Qualified providers who have indicated through the Services and Supports Directory that they are willing and able to provide services necessary to support the individual achieve his or her Outcomes are reviewed with the individual and his or her family, guardian, or advocate. The individual and his or her family exercise choice in the selection of willing and qualified providers.

(B) The Participant's Authority To Determine Who Is Included In The Process.

Prior to the meeting(s), the Supports Coordinator collaborates with the individual/family/provider agency/team to coordinate invitations and ISP/Annual Review meetings dates, times, and locations. The process of coordinating invitations includes the individual's and family's input as to who to invite to the meeting(s).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

The ISP process means working together to share, plan, dream, and create a vision for the future. The ISP is based on self-determination and the philosophies of Positive Approaches, Person Centered Planning, and Everyday Lives. The purpose of Positive Approaches is to enable individuals to lead their lives as they desire by providing supports for them to grow and develop, make their own decisions, achieve their personal goals, develop relationships, face challenges, and enjoy life as full, participating members of their communities. The Core Values of Everyday Lives are choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, success, contributing to the community, collaboration, and mentoring. Person centered planning discovers and organizes information that focuses on an individual's strengths, choices, and preferences. It involves bringing together people the individual would like to have involved in the planning process, truly listening to the individual, describing the individual as fully as possible with a true focus on understanding who he or she is, and dreaming and imagining with the individual of possible ways things could be different, both today and tomorrow. Integrating the values of Positive Approaches, Everyday Lives, and Person Centered Planning into the ISP maximizes individuals' opportunities to incorporate their personal values, standards, and dreams into their everyday lives and their programs, services, and supports. Each team uncovers meaningful personal Outcomes and works towards realizing these Outcomes.

The ISP is developed using a standardized format for all individuals and the planning of their services, that meets federal and state regulations. It contains essential information about the individual, which is used for planning and implementing supports necessary for the individual to successfully live the life that he or she chooses. To address the full range of individual needs, ISPs are based on written assessments or other documentation that supports the individual's need for each Waiver and Non-Waiver funded service.

Completing a person centered ISP is a process that has some specific guidelines while providing opportunities for flexibility with different approaches and creativity with planning. The process starts with assessment and information gathering, followed by an ISP Meeting/Annual Review at which the gathered information is reviewed, outcomes are developed, and services, supports, and providers are identified. Information from the meeting is then documented in HCSIS, the ISP is approved, and then ISP is authorized by the AE,

and services are implemented then monitored. The ISP in HCSIS stores information from an individual's team, which includes the individual and their supports coordinator, and may include family, friends, advocates, and various agencies and providers. Storing the plan electronically affords Supports Coordinators, other designated providers, AE's, and ODP quick accessibility to information.

(A) Who Develops The Plan, Who Participates In The Process, And The Timing Of The Plan

AE's are required to ensure that the supports coordinator develops the ISP based on a team meeting prior to the receipt of waiver services (authorization by the AE). Service providers in licensed settings are required by regulation to participate in the assessment of the individual's needs, and the development of the ISP. Licensed service providers are also required by regulation to implement the plan. Plan Regulations are found in PA Code 55 Chapters 6400, 6500, 2380, and 2390. ODP expects that all waiver providers participate in planning, and attend the ISP meeting, unless otherwise indicated by the participant.

The ISP review meeting must occur at least once every 365 days and changes must be developed and authorized prior to the implementation of services. ISPs must be updated at least within every 365 days and as necessary when the needs of individuals change.

The Supports Coordinator is responsible at least annually for developing ISPs by performing the following roles and functions in accordance with specific requirements and timeframes, as established by ODP:

- Completion of ISP's
- Entering ISP's into HCSIS
- Inviting team members to participate in ISP meetings
- Updating ISP's at least once every 365 days and whenever needs change
- Documenting contacts with individuals, families, providers, or on their behalf
- Recordkeeping
- Locating services
- Coordinating
- Monitoring services
- Monitoring Health and Welfare of waiver participants
- Follow-up and tracking corrective action

As a service provider with vital knowledge about the individual, the provider agency is responsible for the following ISP roles and functions:

- Completing assessments
- Sharing information
- Assuring information is in completed ISP
- Participating in ISP meetings
- Implementing recommended services
- Reviewing plan implementation

Members of the individual's team may include the individual, the individual's parent, guardian or advocate, the individual's direct care staff, the provider program specialist, the supports coordinator, and other specialists if appropriate for the individual's needs.

Upon completion of the plan, the supports coordinator is responsible for ensuring the individual and all team members receive a copy of the finalized plan. Additionally, individuals can receive copies of their service costs upon request to the AE.

(B) The Types Of Assessments That Are Conducted To Support The Service Plan Development Process, Including Securing Information About Participant Needs, Preferences And Goals, And Health Status

The Supports Coordinator begins the assessment and information gathering process by coordinating the information gathering methods with the team. A key step in developing a meaningful ISP is to gather information that reflects the Everyday Lives Core Values. Information should be gathered from the person and those who know him or her best in order to gain and capture person centered information to determine the person's wants, preferences, strengths, and needs. If the person uses an alternate means of communication or if his or her primary language is not English, the information gathering process needs to utilize his or her primary means of communication, an interpreter, or someone who has a close enough relationship with the individual to accurately speak for him or her. When possible, non-waiver services will be specifically identified to address those needs that are not addressed by waiver services.

In September 2007, ODP began to phase-in a statewide standardized needs assessment for planning that is being used to determine intensity of need. The standardized assessment was completed by ODP staff for a small number of specific situations pending the

selection of an assessment contractor. The contractor has been selected, and began to complete assessments in March 2008. The information resulting from the standardized assessment is shared with the Supports Coordinator and team as part of the information gathering process of the ISP and is documented in the information gathering sections relevant to the questions of the ISP. Additionally, there are several different formal and informal tools and methods for collecting information. Personal preferences should be supported for all necessary services. Information gathering should include physical development, communication styles, learning styles, educational background, social/emotional information, medical information, personality traits, environmental influences, interactions, relationships that impact the person's quality of life, and an evaluation of risk. A Lifetime Medical History is completed or reviewed and updated. Lifesharing and employment are discussed with the individual and his or her family to gather information about the individual's preference regarding where he or she wishes to live and work.

The ISP document itself is divided into sections. The first section of the ISP is used to identify information about the person; the next section is summary of the assessment, followed by the outcome summary and an action section. The final section is the identification of who will provide services and the frequency of services that will support the outcome action. The ISP document identifies the following areas that reflect summaries of assessments completed for the planning process: Medical, Developmental Information, Psychosocial Information, Physical Assessment, Health and Safety, Safety Precautions, Supervision Care Needs, Behavioral Support Plan, Health Care Health Promotion, Functional Information, Adaptive/Self-Help, Educational/Vocational Information, Communication, and Financial.

The Supports Coordinator is involved in other assessments depending on the unique needs of the individual. The Supports Coordinator is responsible for documenting assessment information in the ISP in HCSIS. Guidelines are available to all team members and summary sections can be completed by any team member prior to the planning process. The Supports Coordinator is responsible to gather these sections and put them into the ISP documents and make sure the guiding questions are addressed as appropriate in the final document.

(C) How The Participant Is Informed Of The Services That Are Available Under The Waiver

AE's are responsible to ensure all waiver participants are informed of home and community-based services funded through the Consolidated Waiver. Home and community-based services include those services that are sufficient and appropriate home and community-based services and support that an individual needs or is likely to need in the home and community and to avoid institutionalization.

(D) How The Plan Development Process Ensures That The Service Plan Addresses Participant Goals, Needs (Including Health Care Needs), And Preferences

ISP's are based on a written assessment or other documentation that supports the individual's need for each waiver funded service. ISP's are developed to address the full range of individual needs, and thus include both waiver funded and non-waiver funded services necessary to address an individual's needs. In addition to the services that are furnished, ISP's must include the amount, duration, and frequency of each service, and the type of provider to furnish each service.

The individual and his or her family, friends, and team develop Outcome Summaries and Actions to support the attainment of what is important to and for the individual. Outcomes should build on gathered information, reflect the individual's preferences, represent desired changes or important things that should be maintained, make a difference in the person's life, and signify a shared commitment to take action. There is a clear connection between the person's preferences, choices, life aspirations, strengths, and needs that were revealed during the information gathering process and the Outcomes that are developed at the ISP meeting.

The ISP outlines the actions and supports necessary for the person to successfully attain his or her Outcomes. The team uses Outcomes as a guide to determine what services and supports are needed and to assure that services and supports reflect the actions needed to promote the Outcomes. Any barriers or concerns that prevent the Outcomes from being tangible and reachable need to be addressed at this time, especially if these obstacles can impact the individual's health and safety. The person and their team work together to find acceptable Outcomes that enable the person to exercise his or her choices while at the same time minimize risk and achieve or maintain good health. Outcomes may need to be broken down into achievable segments to maximize the individual's opportunities for success.

The standardized ISP format contains the following sections relevant to a participant's goals, needs, and preferences:

INDIVIDUAL PREFERENCES: Like And Admire, Know And Do, Desired Activities, Important To, What Makes Sense

MEDICAL: Medications/Supplements (And Treatments), Allergies, Health Evaluations, Medical Contacts, Medical History

HEALTH & SAFETY: General Health & Safety Risks, Fire Safety, Traffic, Cooking/Appliance Use, Outdoor Appliances, Water Safety (Including Temperature Regulation), Safety Precautions, Knowledge Of Self-Identifying Information, Stranger Awareness, Meals/Eating, Supervision Care Needs, Behavioral Support Plan, Health Care, Health Promotion

FUNCTIONAL INFORMATION: Functional Level, Educational/Vocational, Employment, Understanding Communication, Other Non-Medical Evaluation

FINANCIAL: Financial Information, Financial Management, Financial Resources

(E) How Waiver And Other Services Are Coordinated

When identifying services and supports, the team considers all available resources, including ODP services and natural supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations, and employers. These services are guided by the principles of preventing institutional placement and protecting the person's health and welfare. A list of the services can be found in Appendix C, the current Service Definitions Bulletin, and in HCSIS. Services are outlined in the participant's ISP, which is distributed by the Supports Coordinator to the participant, family member(s), and providers of service. The Supports Coordinator is responsible to ensure that there is coordination between services in the ISP, including maintaining collaboration between ODP-sponsored services and generic and informal supports, as well as ensuring consistency in service delivery among providers.

(F) How The Plan Development Process Provides For The Assignment Of Responsibilities To Implement And Monitor The Plan

Upon authorization of the ISP, supports and services are implemented and each team member is accountable for specific outcomes and supports as assigned.

(G) How And When The Plan Is Updated, Including When The Participant's Needs Change

The ISP and each Annual Review thereafter is developed within the timelines indicated by the applicable licensed service regulations and/or policies for non-licensed services, and Outcomes are developed prior to the implementation of services.

The ISP is updated, approved, and authorized as changes occur and reviewed and updated at least annually (within 365 days).

The Supports Coordinator and team gather information and review the Outcomes and selected services on an on-going basis to assure that the ISP continues to reflect what is important to and for the individual. Revisions are discussed with the individual and/or his or her family, guardian, or advocate and team, entered into the ISP in HCSIS, and shared with the team and service providers.

Regular ISP monitoring assures that the individual is receiving the appropriate quality, type, duration, and frequency of services and benefits. Quality services require a system that acknowledges its strengths and weaknesses through a Quality Improvement Cycle. After the ISP is completed, it is implemented, then checked or monitored, and action is taken based upon the results of the monitoring process.

ISP monitoring is completed by a variety of entities. As a provider of services, the Provider reviews the ISP to assure that the information is complete and accurate and that services are implemented as recommended by the team. Supports Coordinators monitor the ISP using the standardized ISP monitoring tool, and enter results into HCSIS. AE monitoring ensures that reasonable safeguards exist for the person's health and well-being in the home and community. ODP, through the oversight of AE's, monitors individuals' ISPs for compliance with waiver requirements and ISP policies. In addition, the person may be asked to participate in other external monitoring, such as Independent Monitoring for Quality.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

Information gathering includes an evaluation of risk. At the ISP Meeting/Annual Review, the team reviews information that was gathered during the assessment/information gathering stage of the process to assure that identified needs lead to Outcomes and services that are based upon those needs. Information relevant to the individual from Independent Monitoring For Quality, ODP oversight of AE's, Health Care Profiles, Incident Management, complaint resolution, and other feedback shall be incorporated and reviewed annually during individuals' ISPs when that information will impact individuals' health and welfare, services and supports the individual receives, or individuals' ability to have an everyday life.

The ISP outlines the actions and supports necessary for the person to successfully attain his or her Outcomes. The team uses Outcomes as a guide to determine what services and supports are needed and to assure that services and supports reflect the actions needed to promote the Outcomes. Any barriers or concerns that prevent the Outcomes from being tangible and reachable need to be

addressed at this time, especially if these obstacles can impact the individual's health and welfare. The team and the person work together to find acceptable Outcomes that enable the person to exercise his or her choices while at the same time minimize risk and achieve or maintain good health. Outcomes may need to be broken down into achievable segments to maximize the individual's opportunities for success. The ISP team discusses backup plans during ISP planning. For agency-based services, the provider is responsible to identify a contingency plan for backup services. For self-directed services, the participant, their Supports Coordinator, and family or surrogate are responsible to identify backup plans. Supports Broker Services may be used to assist with the identification of backup resources, and the development of backup plans.

If an individual refuses routine medical or dental examination or treatment, the refusal and continued attempts to train the individual about the need for health care shall be documented in the individual's record.

The following are detailed instructions for specific sections of the ISP that relate to the identification and remediation of risk:
INDIVIDUAL SUPPORT PLAN: INDIVIDUAL PREFERENCE: WHAT MAKES SENSE

The What Makes Sense section of the plan is used to capture information about what experiences do and do not make sense in the life of the individual RIGHT NOW. Things that currently occur but do not work and need to be changed may express "What doesn't make sense". This section is the aspect of the planning that bridges the gap between the assessments of what is important to and for the individual and the specific actions that will be taken to assure those things occur in balance. This information helps to set the agenda for what should be changed and what needs to continue. It is based on the perspectives of multiple people who care about the individual. This section is the groundwork for negotiating around areas of disagreement. It is NOT a wish list, nor is it a collection of things that are currently not happening, but we think might be helpful or enjoyable to the individual. It is designed to be a "picture of current reality from multiple perspectives."

INDIVIDUAL SUPPORT PLAN: HEALTH AND SAFETY: FOCUS AREA

The Health and Safety areas of the plan can address the licensing requirements for residential and other licensed services. A summary of the assessment information and the skills and needs in each area should be recorded. Indicate if there is no assessment for a particular area. Each identified risk must address the level of supervision needed for the individual's safety.

General Health and Safety Risks

Self-medication skills and needs and other information pertaining to health and safety other than what is recorded in the other Health and Safety focus areas are documented in this section of the ISP. It also includes the team review of any injuries and accidents that may have occurred over the past year to look for trends in potential areas of concern.

This section includes restraint usage, data, and identifies interventions for supporting the individual during the crisis. It also includes personal health-related skills, such as the ability to self-administer medication and call 911 when necessary.

Water Safety (Including Temperature Regulation)

This section includes information about the individual's ability to understand water safety and temperature safety: Can the individual: temper bath water or water to wash his/her hands, be alone in a shower, be alone in a bath and is the individual safe in a swimming pool? If the individual has a seizure disorder, or other medical condition such as a peg tube, precautions necessary for bathing or swimming are included. The level of supervision and assistance required for hot water usage and when around bodies of water is included.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

Qualified providers who have indicated through the Services and Supports Directory that they are willing and able to provide services necessary to support the individual achieve his or her outcomes are reviewed with the individual and his or her family, guardian, or advocate. The supports coordinator shares this information with the individual and their team during the planning process and ultimately the individual and his or her family exercise choice in the selection of willing and qualified providers. Information from the SSD (Services and Supports Directory) can be reviewed through the Internet, or via hard copy printed by the Supports Coordinator or AE.

Appendix D: Participant-Centered Planning and Service Delivery

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

After the ISP planning meeting, the supports coordinator completes the ISP documentation in HCSIS and submits the plan to the AE for approval. Once approved, the AE authorizes services.

ODP reviews a seven percent sample of ISP's for waiver participants retrospectively as part of the new statewide AE Oversight process that began in April 2007 and is outlined in Appendix A-6. The AE Oversight process involves the review of a representative sample of ISP's to ensure:

- ISP's address all assessed needs;
- ISP's document the frequency, amount, and duration of services, as well as the provider type for each service;
- ISP's address personal goals;
- ISP outcomes relate to the individual's preferences and needs;
- ISP's are updated at least annually, and as needed based on changes in need;
- Team members are invited to ISP meetings;
- ISP's are authorized prior to the receipt of waiver services;
- Information from IM4Q, supports coordination monitoring, incident management, and health risk profiles are reviewed at ISP meetings, and any outstanding issues are addressed; and
- ISP's are distributed to team members.

Other triggers for the review of ISP's include identification of critical individual issues through incident management reviews, ODP Regional Risk Management committee meetings, and/or complaints. ISP's may also be reviewed as part of the ODP Service Review procedures for the review of formal fair hearing requests that involve the denial, reduction, suspension, or termination of waiver services for Consolidated Waiver participants.

ODP retains the final authority related to the content and funding attached to ISP's. ODP reviews a sample of ISP's through the AE Oversight process, which began in April 2007. Any issues identified through the review of ISP's will be presented to the AE for remediation. ODP will expect the AE to outline a plan to correct the issue(s), subject to approval by ODP.

Results and findings related to the review of ISP's are an important component of ODP's quality management strategy, as they relate to the assurance of meeting waiver participants' identified needs. Results and findings are aggregated and are currently reviewed on an annual basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager

■ **Other**

Specify:

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Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(A) The Entity (Entities) Responsible For Monitoring The Implementation Of The Service Plan And Participant Health And Welfare

The ISP is monitored for quality assurance by the AE, the supports coordinator, and ODP. If the AE is also the Supports Coordination organization, the same ISP monitoring requirements apply. Monitoring of ISP's by supports coordinators is documented on a standardized ISP monitoring tool that is entered into HCSIS.

(B) The Monitoring And Follow-Up Method(S) That Are Used

The Supports Coordinator monitors the implementation of the ISP regularly to ensure that the person is receiving the appropriate quality, type, duration, and frequency of services and benefits, and the person is satisfied with the manner in which the services or supports are delivered. Both telephone conversations and face-to-face visits are utilized as monitoring methods.

ODP, through its oversight of AE's, monitors ISP's for compliance with planning outcomes and expectations. In addition, the participant may be asked to participate in other external monitoring, such as Independent Monitoring for Quality surveys and monitoring by AE or ODP staff.

(C) The Frequency With Which Monitoring Is Performed.

Supports Coordination Monitoring Requirements: The AE and ODP are responsible to ensure that monitoring is conducted by supports coordinators at a frequency and duration necessary to ensure services and supports are provided in accordance with the waiver participant's individual support plan, and to ensure the waiver participant's health and welfare. The AE is responsible to ensure the following minimum monitoring requirements are met:

For participants in the Consolidated Waiver who receive a monthly service, the supports coordinator shall conduct a minimum of three (3) face-to-face monitoring visits every three (3) calendar months. Of these visits:

- At least one (1) of the visits must take place at the waiver participant's residence;
- One (1) visit must take place at the waiver participant's day service; and
- One (1) visit may take place at any place agreeable to the waiver participant.

Deviations of the minimum monitoring frequency that involve monitoring at a frequency less than the above requirements are permitted for participants living with family members under the following circumstances:

- *The waiver participant and/or their representative requests the deviation;
- *The deviation is included in the waiver participant's approved ISP; and
- *There are alternative mechanisms in place to ensure the waiver participant's health and welfare, and these mechanisms are included in the participant's approved ISP.

Deviations in monitoring frequency may not result in monitorings that take place at a frequency less than four (4) face-to-face monitoring visits per calendar year. Deviations in monitoring frequency are subject to approval by ODP.

If a monthly service is not provided as per the conditions outlined in Appendix B-6-a-ii, deviations of monitoring frequency and location are not permitted. For these situations, ODP requires a face-to-face ISP monitoring visit by supports coordinators at least once every calendar month during the period of time when a monthly service is not provided.

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

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

ODP has established a conflict-free policy for Supports Coordination providers through provider qualification criteria. Supports Coordination providers that currently provide other direct waiver services must submit a divestiture plan to ODP, as well as detailed information on the administrative procedures that are in place to ensure supports coordinators are free to identify problems with an individual's services, and that individuals have free choice of willing and qualified providers and of conflict-free supports coordination services pending divestiture. Plans are subject to approval by ODP.

The following are mechanisms that are in place to identify potential issues with ISP development by these supports coordination organizations:

1. ODP reviews ISP's retrospectively through the AE Oversight process. The ISP review will be used to identify potential conflict of interest issues in ISP development.
2. ODP maintains a log of all 888 calls and calls that come directly to its Regional offices. This log includes the funding stream and nature of the complaint and allows the ODP Regional Offices to conduct periodic reviews for any apparent trends that would relate to a lack of a conflict-free environment.
3. All ISP's for participants with a County AE are in HCSIS and can be reviewed by ODP. ODP completes regular reviews of ISP's (for both County AE's and non-governmental AE's) as part of the AE Oversight process. Additionally, the annual assessment, ISP outcomes, services notes, and ISP monitoring forms for participants with a County AE are available in HCSIS for review by ODP. ISP's, service notes, and ISP monitoring forms for participants with non-governmental AE's are available for review by ODP upon request.
4. The ODP Regional Offices review all incidents entered into HCSIS, as well as the outcomes of investigations. For AE's providing direct services, the ODP Regional Offices review for discrepancies between the outcomes of the investigations the AE performs on their own agencies and those of their contracted providers. Any questionable findings are researched further by the ODP Regional Office.
5. The Service Review process allows ODP to monitor/track review requests that identify the lack of provider choice as the issue for review.
6. IM4Q includes questions related to choice of providers, and ODP reviews this information through aggregate AE IM4Q reports.
7. ODP has access to information from monitoring that is conducted by supports coordinators using a standardized ISP monitoring tool and entered into HCSIS. Monitoring forms are reviewed as part of ODP's oversight of AE's.

In addition to the above oversight mechanisms, ODP reviews choice of provider through its AE Oversight. The AE Oversight process includes indicators related to choice that will be used to identify potential conflict of interest issues. The ODP AE Oversight team assigned to the AE is aware of their conflict-free status, and verifies that safeguards ensure free choice of willing and qualified providers.

Waiver participants and their families may access the ODP Services and Supports Directory (SSD), which is on the HCSIS homepage, to search for potential providers. The SSD provides the ability to search by geographical area, type of service, and provider name. Waiver participants without Internet access may ask their supports coordinator for assistance, may use a computer in the AE Office to access the SSD, or may ask their SC or AE for a printed copy of the SSD.

AE's are required to contract with any waiver provider that has a signed ODP Medical Assistance Agreement, if a waiver participant and/or their representative requests the services of such provider, the provider agrees to serve the waiver participant, and the provider costs for the service are consistent with efficiency, economy, and are adequate to provide quality of care as per the Administrative Entity Operating Agreement. Issues of noncompliance with the Agreement are addressed through the following remedies: Notification of the noncompliance in writing to the AE Administrator or Director, technical assistance, a required plan of correction, freeze of waiver enrollment by the AE pending an acceptable plan of correction, termination of the Agreement, or non-renewal of the Agreement.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

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

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

Indicate whether Independence Plus designation is requested (select one):

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

All ISP's are participant-centered, and the planning process encourages participants to identify desires, which can be incorporated through natural supports. Plans are developed through a team process, which focuses on a team approach with the participant as the center of the team. Other team members include family and friends, the supports coordinator, service providers, and any natural supports or community resources. Each participant has the choice of willing and qualified waiver providers. ISP's are developed annually and reviewed or revised as is necessary throughout the year.

Participants may learn more about participant direction of services through their supports coordinators, Administrative Entities, ODP, and training resources. Participants may opt to self-direct services at any time through a request to their supports coordinator. The supports coordinator and the participants planning team can then assist the individual in transitioning to participant-direction of services, including the identification of necessary supports to assist the participant with the direction of their services and/or workers.

All participants are offered the opportunity to exercise choice and control over qualified support services workers through the utilization of Intermediary Service Organizations (ISO). ISO services include the Agency with Choice and Vendor Fiscal/Employer Agent models. Participants may utilize one or both models. The Agency with Choice model is currently managed locally through contracts with AE's. AE's will continue to contract with Agency with Choice ISO's as an administrative function in future fiscal years, until otherwise directed by ODP. In the Agency with Choice model, the ISO is the "Employer of Record" of qualified support service workers. Through this model, participants and/or their representatives function as co-managers and work with the ISO to:

1. Recruit and refer qualified support service workers to the ISO for hire;
2. Participate in training of workers;
3. Determine workers' schedules;
4. Determine worker responsibilities; and
5. Manage the daily activities of workers.

In the Agency with Choice model, the ISO is responsible for the following functions:

1. Hiring qualified support service workers referred by participants/representatives;
2. Processing employment documents;
3. Verifying that qualified support service workers meet the qualification standards outlined in Appendix C-3;
4. Obtaining criminal background checks and child abuse checks, if applicable, on prospective employees;
5. Invoicing the AE or PROMISE for service rendered by qualified support service workers;
6. Preparing and disbursing payroll checks;
7. Providing workers compensation for workers;
8. Providing a variety of supports to participants/representatives, to include employer skills training and development of a worker registry; and
9. Conducting worker training.

During fiscal year 2007/2008, the Vendor Fiscal model will be provided locally through contracts with AE's. Beginning in fiscal year

2008/2009, ODP will contract with a statewide entity to provide Vendor Fiscal ISO services. Beginning July 1, 2008, the statewide Vendor Fiscal ISO will be available to interested individuals not currently utilizing the services of a county-contracted Vendor Fiscal ISO. All individuals already utilizing the services of a county-contracted Vendor Fiscal ISO must utilize the statewide Vendor Fiscal effective January 1, 2009. Until the statewide Vendor Fiscal ISO is in place, AE's are responsible to ensure waiver participants have access to this model. In the Vendor Fiscal model, the participant and/or their representative is the "Employer of Record" of qualified support service workers. Through this model, the participant and/or their representative has responsibility for:

1. Recruiting and hiring qualified support service workers;
2. Orienting and training workers;
3. Determining worker schedules;
4. Determining worker responsibilities;
5. Managing daily activities of workers; and
6. Dismissing workers when appropriate.

Under the Vendor Fiscal model, the ISO is responsible for the following functions:

1. Functioning as the employer agent on behalf of the participant/representative;
2. Withholding, filing, and paying Federal employment taxes, State income taxes, and workers compensation on behalf of the participant/representative;
3. Paying workers and vendors for services rendered as per the participant's authorized ISP;
4. Verifying that workers meet statewide qualification criteria for the service(s) they provide;
5. Conducting criminal background checks and child abuse checks, if applicable, on prospective employees; and
6. Providing employer skills materials and training to participants/representatives.

There are currently multiple Vendor Fiscal and Agency with Choice ISO's available through local contracts with AE's across the State. Upon implementation of the Statewide Vendor Fiscal ISO, there will be one Statewide Vendor Fiscal ISO and each AE will be required to contract with an Agency with Choice ISO. This will result in a maximum of 48 Agency with Choice ISO's as AE's have been given the option for a single ISO to contract with multiple AE's.

All participants functioning as the Employer of Record are afforded the budget authority to designate the hourly wage paid to each qualified support service worker, as long as that rate is within the established payment wage range. All participants self-directing their services have the flexibility to shift funds between authorized services with prior notification to their Supports Coordinator.

All participants who use ISO services have the right to receive those services in accordance with the guiding principles of self-determination. This means that ISO services must be provided in a manner that affords participants and their representatives, if applicable, choice and control over the services they receive and the qualified service support workers and providers who provide them.

ODP intends to expand the budget authority afforded to waiver participants, through a waiver amendment. The amendment will provide interested participants with decision-making authority and management responsibility for a participant-directed budget, from which the participant authorizes the purchase of waiver services to meet their needs, as authorized in the ISP.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*
- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

- d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):
- Waiver is designed to support only individuals who want to direct their services.
 - The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
 - The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Currently, participants are provided information and technical assistance on participant direction through a variety of avenues. The AE is responsible to ensure that waiver applicants are provided with information about participation direction during intake and enrollment. Supports coordinators provide participants with information during the planning process, annual ISP review, and upon request. Supports coordinators also provide participants with assistance in making the decision to exercise participant direction authority(ies), and refer participants to other resources (i.e. ISO providers, personal support service providers) as necessary. In addition, ODP sponsored statewide training on ISO's was conducted by ODP staff and a consultant.

Participants can also receive information on participant direction upon request from the supports coordination entity, AE, and ODP.

Information provided to participants by AE's and supports coordinators currently varies across the state. Several AE's have developed information packets that are provided to participants/representatives at intake and/or upon request. A few AE's have also held ISO informational meetings to explain participant-directed services to participants/representatives. Generally, information includes basic information on self-determination and choice options, the benefits and liabilities associated with self-direction of services, as well as the participant/representative responsibilities for self-directed services. By January 2009, ODP will develop a standard participant directed informational packet for distribution by ODP, AE's, supports coordinators, and training contractors.

In addition, ODP contracts with a training partnership through Temple University called the Partnership. The Partnership is a statewide group of organizations that focuses on the needs of people with disabilities and their families and provides education,

technical assistance, support and advocacy. The Partnership provides numerous trainings to individuals and their families, including training on the principles and practices of self-determination and choice. The Partnership offers this training on an ongoing basis across Pennsylvania. Participants learn about Partnership training opportunities through local announcements that are distributed through the local ARC's, AE's, self-advocacy organizations, family organizations, the Partnership website, newsletters, and/or newspaper advertisements. Courses developed by the Partnership are based on needs identified through surveys of participants and family members, and are generally provided to groups. All of the Partnership organizations have a mentoring component to their supports. Additional information on the Partnership can be found at www.thetrainingpartnership.org.

Participants may also utilize Personal Support Services through the Waiver as needed to plan, manage, and organize community resources (see Appendix C-3 for additional details).

Participants who utilize Agency with Choice ISO services may receive assistance in employer-related responsibilities from the ISO. Participants who function as the "Employer of Record" may access training related to employer responsibilities through the statewide Vendor Fiscal ISO on contract with ODP, beginning July 1, 2008 for participants not currently utilizing the services of a county-contracted ISO or January 1, 2009 for participants currently utilizing the services of a county-contracted ISO.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants have the right to have a representative, also known as a surrogate, assist in hiring and managing qualified support service workers who are paid through an ISO. If a representative is desired by the participant, the representative must:

1. Effectuate the decision the participant would make for himself/herself;
2. Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them. Accommodations shall include, but not be limited to, communication devices, interpreters, and physical assistance;
3. Give due consideration to all information including the recommendations of other interested and involved parties; and
4. Embody the guiding principles of self-determination.

If a representative has not been designated by a court, the participant may designate the following surrogate, as available and willing:

1. A spouse (unless a formal legal action for divorce is pending)
2. An adult child of the participant
3. A parent
4. An adult brother or sister
5. Other representative – If the participant desires a representative/surrogate, but is unable to identify one of the above, the participant, along with their supports coordinator, shall identify an appropriate representative/surrogate. The other representative/surrogate should be an adult with knowledge of the participant's preferences and values. The Administrative Entity is responsible to ensure that the selected representative/surrogate is able to assist the individual with the employer-related responsibilities and complies with the requirements outlined above.

A representative may not receive payment for this function. In addition, a representative may not receive payment for any

services the representative provides to the participant.

The ISO must recognize the participant’s representative as a decision-maker, and provide the representative with all of the information, training, and support it would typically provide to a participant who is self-directing. The ISO must fully inform the representative of the rights and responsibilities of a representative. Once fully informed, the ISO must have the representative review and sign an agreement, which must be given to the representative and maintained in the participant’s file. The agreement must: list the roles and responsibilities of the representative; list the roles and responsibilities of the ISO; state that the representative accepts the roles and responsibilities of this function; and state that the representative will abide by the ISO policies and procedures.

ISP monitoring takes place with each participant at the minimum frequency outlined in D-2-a. Several questions on the standard ISP monitoring tool can prompt the identification of any issues with the representative not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by supports coordinators, their supervisors, and/or the AE.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Companion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homemaker/Chore	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home and Community Habilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Accessibility Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Accessibility Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supports Broker Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.**

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

--

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Currently, ISO services through the Agency with Choice and Vendor Fiscal models are provided locally by private entities with contracts with AE's (see Appendix E-1: a). Local ISO's were identified using a variety of mechanisms including recruiting ISO's, developing an ISO mailing list, preparing and distributing a briefing paper on self-determination and the use of ISO's, and developing and implementing a request for information (RFI). Vendor Fiscal ISO services must be provided in accordance with the US IRS rules and regulations, US Department of Labor and state and local rules and regulations pertaining to domestic service workers and employer agents, and 55 PA Code Chapter 4300 regulations. Agency with Choice ISO services must be provided in accordance with 55 PA Code Chapter 4300 regulations and federal and state waiver regulations and policies.

Beginning in fiscal year 2008/2009, ODP will contract with a statewide Vendor Fiscal/Employer Agent ISO (in accordance with section 3504 of the IRS Code and IRS Revenue Procedure 70-6). The statewide Vendor Fiscal will be selected through a state-level contracting process.

AE's will continue to contract with private entities for the Agency with Choice ISO model.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Currently, Agency with Choice and Vendor Fiscal ISO's receive payment for administrative activities through a contract with an AE. AE's will contract with Agency with Choice ISO's until otherwise directed by ODP. AE's will contract with local Vendor Fiscal ISO's until March 2009 (Functions beginning January 1, 2009 and ending March 31, 2009 are only for tax reporting purposes as individuals will be transitioned to the statewide Vendor Fiscal ISO effective January 1, 2009.). AE's have established administrative rates paid to local ISO's that are consistent with 55 PA Code Chapter 4300. Administrative rates may involve a per transaction fee or a monthly fee per participant. The established administrative rate must be applied consistently with each participant within the AE. Local Agency with Choice ISOs will bill PROMISE and receive payment directly from the Pennsylvania Treasury by July 1, 2009.

Beginning in fiscal year 2008/2009, ODP will contract with a statewide Vendor Fiscal ISO. ODP will pay the statewide Vendor Fiscal ISO a monthly fee per participant for the administrative costs incurred during the span of the contract.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**

- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

Criminal background check
Qualifications check

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The local Agency with Choice and Vendor Fiscal/Employer Agent ISO's are monitored by AE's. AE's are required to monitor ISO performance, payments, and contract conditions at least annually. AE's must ensure that ISO's are in compliance with PA Code Chapter 4300 regulations. AE's are also responsible to ensure that supports coordinators monitor the services and supports paid for through the ISO, at the minimum frequency established by ODP (see Appendix D-2: a).

The statewide Vendor Fiscal/Employer Agent will be monitored on an ongoing basis by ODP. ODP will monitor the ISO's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. ODP will also monitor claims submitted to PROMISE by the ISO. AE's are also required to report any issues with the statewide ISO's performance to ODP, pursuant to the AE Operating Agreement.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction

is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Supports coordinators provide participants with information during the planning process, annual ISP review, and upon request. Supports coordinators also provide participants with assistance in making the decision to exercise participant direction authority (ies), and refer participants to other resources (i.e. ISO providers, personal support service providers) as necessary.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Nursing	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Home Finding	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Education Support Services	<input type="checkbox"/>
Supports Broker Services	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing

performance:

Participants who function as the “Employer of Record” may access training through the statewide Vendor Fiscal ISO on contract with ODP, beginning July 1, 2008 for participants not currently utilizing the services of a county-contracted ISO or January 1, 2009 for participants currently utilizing the services of a county-contracted ISO. Training that will be available to participants and/or their representatives includes an Individual Enrollment Packet; Orientation and Skills Training Manual that includes information on effectively hiring, managing, and discharging workers; an Orientation Program; and Employer Skills Training.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

If an individual functioning as the “Employer of Record” voluntarily terminates participant direction, the supports coordinator will provide the individual with options to choose the Agency with Choice ISO model or agency-based service options to meet their needs. Both participant-directed services and traditional service models provide similar services to meet the individual’s needs.

If an individual is utilizing Agency with Choice ISO services and voluntarily terminates participant direction, the supports coordinator will provide the individual with agency-based service options to meet their needs. The supports coordinator is responsible to ensure an effective transition between participant directed and traditional services so that there are no gaps in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Involuntary termination will occur if the individual or their representative is suspected or convicted of Medicaid fraud or if the participant fails to meet the conditions of their agreement with the ISO. Involuntary termination will also occur if there is evidence through supports coordination monitoring that the individual’s assessed needs cannot be met through participant directed services. All involuntary terminations must be approved by the appropriate ODP Regional Office.

If an individual functioning as the “Employer of Record” is involuntarily terminated from participant direction, the supports coordinator will provide the individual with options to choose the Agency with Choice ISO model or agency-based service options to

meet their needs. Both participant-directed services and traditional service models provide similar services to meet the individual’s needs.

If an individual is utilizing Agency with Choice ISO services and is involuntarily terminated from participant direction, the supports coordinator will provide the individual with agency-based service options to meet their needs. The supports coordinator is responsible to ensure an effective transition between participant directed and traditional services so that there are no gaps in service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

Waiver Year	Employer Authority Only Number of Participants	Budget Authority Only or Budget Authority in Combination with Employer Authority Number of Participants
Year 1	<input type="text"/>	<input type="text" value="1200"/>
Year 2	<input type="text"/>	<input type="text" value="1200"/>
Year 3	<input type="text"/>	<input type="text" value="1200"/>
Year 4 (renewal only)	<input type="text"/>	<input type="text" value="1200"/>
Year 5 (renewal only)	<input type="text"/>	<input type="text" value="1200"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:
 - i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Private entities function as Agency with Choice ISO’s through local contracts with AE’s. Under the Agency with Choice model, the ISO and the participant/representative must work together effectively as a team to: 1. Offer a high level of choice and control to participants/representatives, and 2. Minimize any employer liability for the ISO and the participant/representative. The focus of the Agency with Choice ISO is to afford participants/representatives with the ability to be effective managing employers (The ISO is the “Employer of Record”; however, the participant/representative engages in managing functions, including recruiting and referring workers to the ISO for hire, managing worker day-to-day responsibilities and schedules, and discharging workers from the home when necessary.). The ISO must fully embrace and apply the philosophies of self-determination and self-directed support services by providing participants/representatives with a high level of choice and control over the support services they receive and the workers who provide them. Agency with Choice ISO’s are responsible to develop and maintain a system and written policies and procedures that afford participants/representatives with the ability to recruit, interview, and select qualified support service workers for hire by the ISO; as well as the ability to be managing employers.

The AE is responsible to ensure that participants/representative utilizing the Agency with Choice ISO model are afforded with choice and control over their services and workers. Supports coordinators, through regular ISP monitoring, monitor the health, welfare, and quality of services and supports provided in accordance with the participant's approved ISP. Participants/representatives may discuss concerns regarding limits on choice and control with supports coordinators, supports coordination supervisors, and AE's. Participants/representatives may also contact ODP through the Regional Office or the ODP Customer Service Number (1-888-565-9435).

ODP uses a consultant to assist with the development and revision of ISO policies and the contracting process for the statewide Vendor Fiscal ISO. The consultant will assist ODP with the revision of the current Bulletin on ISO's, prior to the implementation of the statewide Vendor Fiscal ISO. The revision will include expanded safeguards to ensure that participants/representatives utilizing the Agency with Choice ISO maintain control and oversight of qualified support service workers. ODP will share the revised draft with CMS prior to its implementation.

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the State's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

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

Currently, as part of the planning process, a needs assessment is conducted. The needs assessment results in the identification of the participant's needs. The assessed needs are discussed by the planning team as part of the planning process. The planning process results in the development of an individual support plan based to meet the participant's assessed needs. The individual budget is established based on the waiver services included in the plan. The participant-directed budget is comprised of the services that the participant and/or their representative can and opts to self-direct.

AE's must provide ISO's with the section of a participant's authorized ISP that outlines all services and supports for which the ISO is or will be making payment, the participant's authorized budget, as well as any updates that are made to these two documents that impact ISO services. The participant's authorized budget must include the payment rate for the services and supports for which the ISO is or will be making payment.

Beginning in September 2007, ODP began to implement the Supports Intensity Scale (SIS) as the statewide standardized needs assessment. As per a rollout plan the SIS will be completed for each waiver participant to consistently identify the level of support needed. It is anticipated that the rollout plan will involve the completion of approximately 750 SIS assessments per month. The results of the SIS are provided to the participant and their planning team. As part of the planning process, the team reviews the level of support indicated by the SIS, and determines the specific services and number of units that are needed to meet the support need. By July 1, 2009, ODP will establish state-set rates for the following services that are part of the participant directed budget: Unlicensed Home and Community Habilitation, Supported Employment, Transitional Work Services, Personal Support Services, Home Finding, Homemaker/Chore, and Respite. The fees for Environmental Accessibility Adaptations, Adaptive Appliances/Equipment, and Transportation are based on actual costs. Until implementation of the state-set rates for participant directed services, the unit cost for these services will be determined through the completion of the appropriate standard rate setting spreadsheet as per the statewide rate setting guidelines. The unit cost, along with the participant directed services and units in the participant's approved plan, will be used to calculate the participant directed individual budget. The process to calculate the budget will be made public.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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

The supports coordinator informs the waiver participant of the amount of their participant directed budget subsequent to the development and authorization of the plan. Participants may request an adjustment in their participant directed budget amount through their supports coordinator to accommodate changes in need. If a budget adjustment is denied or the participant's budget amount is reduced, the Administrative Entity is responsible to provide written notice and appeal rights to the participant. The participant may choose to appeal the denial or reduction through a formal fair hearing.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

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

Expenditure of participant directed budgets is monitored by the AE and the ISO. The AE monitors expenditures through the review and payment of claims. Agency with Choice ISO's invoice for services provided, and also process and disburse payroll checks, and are responsible to do so in accordance with the participant's authorized ISP. The Vendor Fiscal ISO on contract with the State will be responsible for tracking budget funds received and disbursed, as well as remaining balances for each participant; tracking, collecting, and reporting financial transactions made on behalf of participants; and distributing monthly utilization statements to participants.

Standardized ISP monitoring is used to identify and address potential service delivery problems, including those associated with over- or under-utilization of authorized services. The statewide Vendor Fiscal ISO will also monitor participant and/or

their representative's satisfaction with the participant-directed services they receive.

If budget issues, such as over-utilization or under-utilization, are recognized, the supports coordinator and/or the Vendor Fiscal ISO are responsible to promptly notify the Administrative Entity. The Administrative Entity is responsible to review the situation and ensure that necessary plan and budget changes are made in a timely fashion.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The participant's right to appeal a denial, reduction, or termination of services is currently detailed in Bulletin 00-08-05 entitled "Due Process and Fair Hearing Procedures for Individuals with Mental Retardation".

As per these procedures, the participant or the participant's surrogate has the right to request a fair hearing before the Department of Public Welfare, Bureau of Hearings and Appeals, for any of the following adverse actions:

1. The individual with mental retardation who is determined likely to meet an ICF/MR level of care and is enrolled in Medical Assistance or surrogate is not given the opportunity to express a service delivery preference for either Waiver-funded or ICF/MR services.
2. The individual or surrogate is denied the individual's preference of Waiver-funded or ICF/MR services.
3. Based on a referral from the AE or County Program, a Qualified Mental Retardation Professional (QMRP) determines that the individual does not require an ICF/MR level of care as a result of the level of care determination or re-determination process and eligibility for services is denied or terminated.
4. The individual or surrogate is denied Waiver-funded service(s) of the individual's choice, including the amount, duration, and scope of service(s).
5. The individual or surrogate is denied the individual's choice of willing and qualified Waiver provider(s).
6. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the individual's ISP. An individual or surrogate may indicate agreement to the services in the ISP by signing the signature page; however, the individual or surrogate may file a request for a fair hearing regarding those services if any services were reduced, suspended, changed, or terminated.

The individual or the individual's surrogate has the right to request a pre-hearing conference with the AE (55 Pa.Code § 275.4(a)(3)(ii), relating to Procedures). The pre-hearing conference is optional for the individual or surrogate. The pre-hearing conference gives both parties the opportunity to discuss and attempt to resolve the matter prior to the hearing. Neither party is required to change its position. The pre-hearing conference does not replace or delay the fair hearing process. The date of the pre-hearing conference and notes of the discussion should be entered in a service note or the appropriate eligibility screen in HCSIS.

Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AE participation is expected whenever the CAO sends a notice confirming the level of care determination and the individual or surrogate appeals that notice through the CAO. The AE will receive notice of the hearing from the Department.

Title 55 PA Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department." This includes the AE. The AE is responsible for ensuring that individuals receive whatever help is needed to fill out and file the appeal form [see 55 PA Code §275.4(a)(1)].

The AE must send a written notice to the participant or surrogate, the Supports Coordinator, and associated providers of service, if applicable, for the following reasons:

1. The individual is determined likely to require an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care and is

provided information about Waiver-funded services.

2. The individual who is determined likely to meet an ICF/MR level of care and is enrolled in Medical Assistance or surrogate is asked to sign the service delivery preference form (DP 457).
3. A decision or an action is taken that affects the individual's claim for eligibility or receipt of services. This applies to the individual's annual planning meeting as well as to any meeting or time that services are discussed with the individual or surrogate. This would also be the basis for appeal if the application for services is not processed within the Department's established timelines.
4. A decision or an action is taken to deny the individual a Waiver-funded service or to deny a willing and qualified provider of the individual's choice.
5. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service that is authorized on the individual's ISP. A delay of services to an individual based on the availability of Waiver funds or on a waiting list situation may be appealed on this basis.
6. The individual or surrogate notifies the AE or County Program of the decision to file an appeal, or requests information about the individual's appeal and fair hearing rights under the Waiver.

A written notice is required to be sent to the individual or surrogate at the time of any action affecting the individual's claim for services. In addition, the AE is required to provide an advance written notice of at least 10 calendar days to the participant or surrogate anytime the AE initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the AE, shall contain a date that the appeal must be received by the AE to have the services that are already being provided at the time of the appeal continue during the appeal process. The 10 calendar day advance notice is based on the mailing date (postmark) of the written notice.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the AE, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa.Code § 275.4(a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the AE. The postmark of a mailed appeal will be used to determine if the 13 day requirement was met by the participant or surrogate. If the AE initiates an action on Waiver services and does not provide the written notice as required, the participant will have 6 calendar months from the effective date of the action to file an appeal. When this appeal is filed, services will be reinstated retroactively to the date of discontinuance and will continue until an adverse decision is rendered after the appeal hearing. A service that is denied prior to being included on an authorized ISP can be appealed, but is not subject to the continuation pending the appeal.

Fair hearing requests are collected in a statewide database and due process is monitored through the AE Oversight process.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
 - No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals shall receive notice of their due process rights and information on how to file for an appeal at the time of their initial enrollment with the AE; upon enrollment in the waiver; at the ISP meeting and upon notification of denial, reduction, suspension or termination of services. The AE shall provide advance notice of denial of service[s] or denial of services at the requested level, reduction, suspension, or termination of service. Supports coordinators are required to provide assistance to individuals to file for appeal. An individual may have a representative/surrogate or advocate assist them with filing the appeal.

In the event an individual has been denied services, or services have been reduced, suspended or terminated, and they were not provided advance notice and information on how to file an appeal, the individual may submit a written request to the AE, with a copy sent to the appropriate ODP regional office. The AE will have an opportunity to review the circumstances, and either provide the service requested, provide advance notice of denial, reduction, suspension or termination of services or provide the individual/family with information regarding their right to appeal to BHA. The AE must notify the ODP Regional Office of its actions within five (5)

days of receipt of the written request.

When an individual/family submits a copy of the Fair Hearing Request Form to the AE in accordance with Bulletin 00-08-04, Due Process and Fair Hearing Procedures for Individuals with Mental Retardation; the AE must date-stamp the appeal upon receipt and forward it to BHA and the appropriate ODP Regional Office, based on the individual's County of registration within 3 working days of receipt of the appeal.

Upon receipt of a fair hearing request, the ODP Regional Office will conduct a service review as per Bulletin 00-06-13, entitled, "Service Review Protocol for Individuals in the Consolidated and Person Family Directed Support Waivers", or any approved revisions.

ODP's Regional Reviewer will review the reasons for appeal, review additional information, and at their discretion, may contact the individuals/families and/or the AE in order to obtain any clarification needed as part of their review. Either party, once an appeal has been filed, may provide written information to ODP within five (5) calendar days following receipt of the appeal.

ODP will determine if the AE actions were consistent with waiver requirements. ODP must ensure that the AE's determination was based upon the correct interpretation of regulations, the current Waiver; the state plan; the current Service Definitions and Service Delivery Preference bulletins; and all other pertinent ODP Bulletins.

The Regional Reviewer will document their service review. The service review will include: a description of the appeal; what materials were reviewed; who, if anyone, the regional reviewer communicated with; their findings and recommendations; and the basis for their recommendations. The regional service reviews are subject to concurrence by the ODP Area Directors. ODP's findings will be mailed to the participant, their family or representative, the AE and BHA within fifteen (15) calendar days following receipt of the appeal.

AE's are generally required to maintain services pending appeal when the appeal has been filed within ten (10) days of being informed of the action until the appeal is resolved in accordance with MR Bulletin 00-08-04.

ODP is responsible to assure that its service reviews, and all decisions from BHA are implemented in a timely manner. When ODP's service review requires a service to be provided, the AE shall initiate such services promptly, at least within thirty (30) days of the service review, or in the case of services that require additional funding, within thirty (30) days beyond receipt of notification of additional funding. Although the AE is provided with these time limits, every effort should be made to initiate the services in a more timely fashion. The AE shall modify the individual's ISP, authorize the services and document the start date of the services in HCSIS. If the AE experiences delays in implementing the service[s], they shall request an extension from the ODP regional office.

If an AE fails to implement the findings from ODP, the ODP regional office will notify the AE, in writing, that services must be either implemented within no later than fifteen (15) days of the notice, or the AE must provide documentation of good faith efforts to implement the service, including the barriers to successful implementation. If there is continued failure to implement the service, the ODP regional office will notify the County Commissioners/AE Governing Board of the program's failure to provide waiver services in accordance with their Operating Agreement and require an immediate plan from the Commissioners/AE Governing Board to comply. Any further failure to implement the service will result in sanctions being imposed.

ODP tracks the reasons for appeals and analyze findings to identify any patterns or trends that may have policy and/or training implications. ODP will routinely review these procedures and revise them as needed. Additionally, ODP will routinely advise AE's statewide of a summary of its findings and recommendations.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

The Office of Developmental Programs is responsible for the operation of a grievance/complaint system.

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

The grievance/complaint system is not a prerequisite for fair hearings. ODP's grievance/complaint system is comprised of two main components. The first is an 888 number; the second is via email through the DPW website. Participants, family members and representatives, Administrative Entities, providers, advocates, and interested others may use these two grievance components to ask questions, request information, or report any type of issue or complaint, including issues/complaints regarding AE performance. The Customer Service line (1-888-565-9435) is a general information line operated by ODP. The phone is located at ODP Headquarters and staffed by Program Specialists from the ODP Bureau of Program Operations during normal business hours. These staff are referred to as the Customer Service Team. The 888 number receives a wide array of questions which include, but are not limited to grievances and complaints. The following information is specific to grievances and complaints. Individuals calling the 888 line with a complaint/grievance are logged into an ACCESS database. After a call is properly documented it is forwarded to ODP regional, or headquarters staff for resolution. Documentation of the resolution is emailed to the Customer Service Manager for review and entry into the database. All calls are expected to be responded to within one business day.

The second component of the complaint system is email. The DPW website provides recipients the option to "contact ODP," once a recipient chooses this option they are directed to an email template which will be sent to ODP. The process for internet inquiries mirrors that of the 888 calls. The call template is not used due to the email already existing in a written template format. All internet inquiries are expected to be responded to within two business days. The complaint system for both internet inquiries and calls received via the 888 number are formally addressed in Protocol & Procedure entitled Customer Service Responsiveness. The Customer Service Manager generates quarterly and annual reports outlining the total number and category of calls/inquiries received statewide, as well as their source; total number of open and closed calls/inquiries; and a breakdown of calls/inquiries by the timeliness of response. Reports are reviewed, and have been used to revise policies and processes.

In addition all ODP regional offices utilize a "duty officer" system whereby assigned staff are responsible for any complaints/grievances received directly at the regional office. Phone calls and letters are also received directly at ODP Headquarters and responded to accordingly.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

Entities required to report critical events have been identified in ODP Bulletins and Regulations. The entities required to report critical events (or "incidents" as defined by ODP in Pennsylvania) are defined in ODP Incident Management Bulletin 6000-04-01 as:

§6000.901. Scope.

(a) Individuals who are registered with a county mental retardation program or who receive supports and services from facilities licensed by the ODP are afforded the protections detailed in this subchapter.

(b) Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a county mental retardation program and providers licensed by ODP are reporters and are to file incident reports as specified in this subchapter.

(c) County Mental Retardation Programs and Support Coordination entities are reporters and are to file incident reports as specified in this subchapter.

ENTITIES RESPONSIBLE FOR REPORTING

§ 6000.911. Providers.

Employees, contracted agents and volunteers of providers covered within the scope of this subchapter are to respond to events that are defined as an incident in this subchapter. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter

and point person. The protection may include, dialing 911, escorting to medical care, separating the perpetrator, calling ChildLine, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual's family within 24 hours, or within 72 hours for medication error and restraint, of the occurrence of an incident and to also inform the family of the outcome of any investigation.

§ 6000.912. Individuals and families.

(a) Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home, they should contact the provider or their supports coordinator, or both and they may also contact the Office of Developmental Programs directly at 1-888-565-9435. As specified in this subchapter, the supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator.

§ 6000.913. County mental health/mental retardation programs.

(a) (a) When an individual or family informs their supports coordinator that an event has occurred that can be defined as an incident and there is a relationship as specified in § 6000.911(b) (1) - (3), (relating to providers) the supports coordinator is to immediately notify the provider rendering the support or service. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report in HCSIS.

(b) When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship as specified in § 6000.911(b) (1) - (3), the supports coordinator will take prompt action to protect the individual. Once the individual's health and safety are assured the supports coordinator will ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.

(c) When a family member of an individual informs the individual's supports coordinator of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report in HCSIS.

(d) In some circumstances, county mental retardation program staff may be required to report incidents. County staff are to report deaths and incidents of alleged abuse or neglect when a provider or supports coordinator relationship does not currently exist, or in circumstances when the process for reporting or investigating incidents, described in this subchapter, for providers or support coordination entities compromises objectivity.

(e) If a county incident manager or designee is informed that a provider's certified investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, the county is to take all available action to protect the health and safety of the individual. The county may need to employ the resources of law enforcement, ChildLine, area agency on aging, counselors or other protective service agencies to protect the individual.

METHODS OF REPORTING INCIDENTS

There are two methods an entity can use to report a critical incident. These methods include an electronic and a non-electronic means. The primary method used to report incidents is HCSIS. HCSIS allows for the consistent reporting of incidents throughout the Pennsylvania mental retardation system, and allows the user to communicate an incident quickly and efficiently. HCSIS also allows the entity user to relay incident information to the appropriate AE and to ODP in a few steps.

An additional means of reporting is the use of the ODP Customer Service Line. ODP Customer Service team members record information received from the caller and communicate the information to the appropriate ODP regional office. This method of reporting allows the individual to remain anonymous.

INCIDENT CATEGORIES

The following are categories of incidents to be reported using a standardized incident report that is comprised of two components, the first section and the final section. For these incident categories, the first section must be submitted within 24 hours of the occurrence or discovery of the incident. The first section of the incident report includes individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. The final section of the incident report must be submitted through HCSIS within 30 days of the incident's recognition or discovery, and must contain all of the information from the first section as well as additional specific information relevant to the incident. If the provider agency determines they will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to the AE and the ODP regional office by means of HCSIS prior to the expiration of the 30-day period.

Abuse. - The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not on the person committing the abuse

Physical abuse – An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.

Psychological abuse– An act, other than verbal, which may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual.

Sexual abuse– An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

Verbal abuse. – Verbalizations that inflict or may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual.

Improper or unauthorized use of restraint. – A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

Death. – All deaths are reportable.

Disease Reportable to the Department of Health – An occurrence of a disease on The Pennsylvania Department of Health List of Reportable Diseases. The current list can be found at the Department of Health's website, www.health.state.pa.us. An incident report is required only when the reportable disease is initially diagnosed.

Emergency closure. – An unplanned situation that results in the closure of a home or program facility for one or more days. This category does not apply to individuals who reside in their own home or the home of a family member. (This may be reported as a site report.)

Emergency room visit.– The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.

Fire. – A situation that requires the active involvement of fire personnel, i.e. extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This (may be reported as a site report.)

Hospitalization. – An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

Individual-to-individual abuse. – An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse. Individual Abuse is reported on from the victim's perspective, not on the person committing the abuse.

Injury requiring treatment beyond first aid.– Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room.

Law enforcement activity.– The involvement of law enforcement personnel is reportable in the following situations:

- (i) An individual is charged with a crime or is the subject of a police investigation which that may lead to criminal charges.
- (ii) An individual is the victim of a crime, including crimes against the person or their property.
- (iii) A crime such as vandalism, or break-in that occurs at a provider site. This may be reported as a site report.
- (iv) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.
- (v) A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.
- (vi) A crisis intervention involving police/law enforcement personnel.
- (vii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.

Missing person.– A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in "immediate jeopardy" based on the person's personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual and/or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.

Misuse of funds– An intentional act or course of conduct, which results in the loss or misuse of an individual's money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for

use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

Neglect. – The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

Psychiatric hospitalization. – An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, or both, whether voluntary or involuntary. This includes admissions for “23 hour” observation and those for the review and/or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.

Rights violation. – An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include but are not limited to, the unauthorized removal of personal property, refusal of access to the telephone, privacy violations, and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

Suicide attempt. – The intentional and voluntary attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.

The following incident categories are reported using a standardized abbreviated HCSIS incident management data entry screens, designed to gather relevant data about these incidents. Data must be input within 72 hours of the recognition or discovery of the event:

Medication error - Any nonconforming practice with the “Rights of Medication Administration” as described in the ODP Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form.

Restraints - Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual’s body, including those that are approved as part of an individual support plan or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category.

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

ODP has purchased the license for the College of Direct Support for the use by AE’s, supports coordination entities, providers, families and individuals. This is a web based interactive curriculum that is grounded in a Code of Ethics for Direct Support Professionals and developed by national experts. Pennsylvania currently has over 21,000 learners. Several courses are directly relevant to protection from abuse, neglect and exploitation for the individuals we support, including:

- o Maltreatment of Vulnerable Adults and Children
- o Individuals Rights and Choice
- o Positive Behavior Support
- o Safety at Home and in the Community
- o Cultural Competence
- o Communication (to be added within the next several months)

Individuals and families without access to a personal computer may access the courses at AE and Supports Coordination Entity offices, as well as libraries and other computer labs. Face-to-face training on sexual abuse awareness is available for individuals through ODP’s Training Partnership.

Additionally, ODP has issued an Incident Management statement of policy which establishes processes that will ensure the health and safety, enhance dignity and protect the rights of individuals who receive supports and services.

- Anyone can call to report an abuse/neglect allegation by calling the widely published ODP toll free number. This action prompts an investigation of the allegations by the AE or the Regional ODP Office, depending on the nature of the allegation. The Regional Office is responsible to verify that the investigation was fully completed and that appropriate action has been taken. Appropriate actions often include plans of corrections that address training needs.
- In addition, to support this approach, ODP has in place a Certified Investigation course for Providers, AE’s and ODP staff. The course is both value and competency based.
- Each ODP Regional Office has assigned a Community Advocate who is employed by Pennsylvania Disability Rights Network. The advocates serve as a local resource to individuals and families as well as an external source for the Regional Offices.
- ODP analyzes reported incidents individually and in aggregate. Based on this review, targeted initiatives are developed. An example of an initiative is the use of restraint data to identify the unique individuals being restrained and target interventions to those

specific initiative individuals. This work improved DPW's current endeavor to address restraint elimination. ODP is working to build capacity in the regional and local level to support positive practices.

- Another contracted specialist is available to work with local teams to address sexuality issues.
- ODP is a member of cross system State advocacy group whose mission is to provide support for individuals who have been victimized. This group's focus is on providing information and training to community services such as rape crisis centers to ensure that the individuals with disabilities that they may serve have proper support and that the centers know the additional community resources that can be made available to individuals.

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

Reports

Providers and AE's enter reportable incidents into HCSIS. Each reportable incident is accessible by the ODP regional office for review and approval. AE's review the first section of the incident report within 24 hours of submission and complete the management approval within 30 days of the submission of the final section. The same process occurs at the ODP regional level. ODP Regional approval of incidents must meet criteria within the Incident Management Closure Protocol. Incidents are reviewed at the ODP regional level in aggregate minimally once a month or as needed through ODP Regional Risk Management meetings. The ODP regional office identifies patterns and trends and develops improvement strategies. If improvement strategies have been implemented the ODP regional office monitors the data to evaluate the effectiveness of the interventions. Statewide analytical reports of incident and licensing data will be compiled and presented to the ODP Leadership Board and Central Office Waiver Assurance Oversight Group for review and to make recommendations for action.

Providers

- Employees, contracted agents and volunteers of providers covered within the scope of the Incident Management policy are to respond to events that are defined as an incident in the policy. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include dialing 911, escorting to medical care, separating the perpetrator, calling ChildLine, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the ISP, the provider point person or designee is to inform the individual's family within 24 hours, or within 72 hours for medication error and restraint, of the occurrence of an incident and to also inform the family of the outcome of any investigation.
- After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are:
 - a. Rendered at the provider's site.
 - b. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer.
 - c. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.
- In situations when multiple providers learn of an incident, the provider responsible for the individual at the time the incident occurred is to report the incident and conduct any required investigation. If it cannot reasonably be determined which provider had responsibility at the time of the incident, all providers who are aware of the incident are to report the incident and investigate.
- If, during an investigation, the certified investigator assigned by the provider determines that an alleged perpetrator is not an employee, a volunteer or an individual receiving services from the provider, the certified investigator is to complete the investigation summary in HCSIS incident management application stating the reason why the investigation could not be concluded. The certified investigator is to review the protective action taken by the agency and ensure communication with county staff occurs, outside HCSIS, to alert the county that appropriate interventions may be needed to protect the individual.
- In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified in § 6000.911(b)(1)-(3), (relating to providers) the provider is not to report the incident in HCSIS, but instead should give notice of the incident, outside of HCSIS, to the individual's supports coordinator.
- Any person, including the victim, shall be free from intimidation, discriminatory, retaliatory or disciplinary actions exclusively for the reporting or cooperating with a certified investigation. These individuals have specific rights as defined by the Whistleblower Law (43 P.S. §§ 1421-1428) and the Older Adults Protective Services Act (35 P.S. § 10225.5102). The provider, AE, and ODP are responsible to ensure these rights are guaranteed. Violations of the Law and Act, as well as the Incident Management policy, by the provider can result in licensing citations, suspension or disqualification, and other legal ramifications.
- If, during an investigation, the certified investigator assigned by the provider determines that an alleged perpetrator is not an employee, a volunteer or an individual receiving services from the provider, the certified investigator is to complete the investigation summary in the HCSIS incident management application stating the reason why the investigation could not be concluded. The certified investigator is to review the protective action taken by the agency and ensure communication with county staff occurs, outside HCSIS, to alert the county that appropriate interventions may be needed to protect the individual

Supports Coordinators.

- When an individual or family informs their supports coordinator that an event has occurred that can be defined as an incident and there is a relationship to the provider as specified in §6000.911(b)(1)-(3) of the Incident Management Bulletin the supports coordinator is to immediately notify the provider rendering the support or service. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report in HCSIS.
- When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship to the provider as specified in §6000.911(b)(1)-(3) of the Incident Management bulletin, the supports coordinator will take prompt action to protect the individual. Once the individual's health and safety are assured the supports coordinator will ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.
- When a family member of an individual informs the individual's supports coordinator of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report in HCSIS.

County Mental Health/Mental Retardation Programs.

- In some circumstances, county mental retardation program staff may be required to report incidents. County staff are to report deaths and incidents of alleged abuse or neglect when a provider or supports coordinator relationship does not currently exist, or in circumstances when the process for reporting or investigating incidents, described in this subchapter, for providers or support coordination entities compromises objectivity.
- If a county incident manager or designee is informed that a provider's Certified Investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, the county is to take all available action to protect the health and safety of the individual. The county may need to employ the resources of law enforcement, ChildLine, area agency Area Agency on Aging, counselors or other protective service agencies to protect the individual.

Review of Incidents:

The process and procedures of reviewing of incidents on the statewide and regional level is defined in Bulletin number 00-06-11, entitled "Provider and County Incident Management Analysis Report" (issued June 23, 2006). The purpose of this Bulletin is to describe the delivery of Incident Management (IM) Trend and Quality Performance Reports (aggregate data), components of the IM Analysis Report templates, and submission dates for the Provider and County IM Analysis Reports.

Upon review of the provided Trend and Quality Performance Reports, Providers and Counties are to complete and submit a single qualitative IM Analysis Report semi-Annually. Provider reports should be submitted via e-mail to each AE with whom a person is registered. Counties are to forward their report to the appropriate ODP regional office.

The counties review all submitted provider reports and provide feedback to the providers. This feedback may include recommendations for improving risk management/quality management processes or offers of technical assistance. The ODP regional office's Risk Management Committees review all submitted county reports and provide feedback to the counties and the Statewide Risk Management Workgroup.

The formal process for the Statewide Risk Management Workgroup to complete a statewide Incident Management (IM) Analysis Report that will provide completed aggregate IM data analysis and recommendations on statewide system improvements is currently being finalized within ODP.

Currently, ODP Regional offices are reporting IM data and developing regional action plans to address the steps and recommendations regarding the statewide initiative to eliminate the use of restraint. The Statewide Positive Practices Committee is also charged with this data analysis, operational recommendations, and program support.

The Incident Management Trend and Quality Performance Reports data delivery process is aimed at providing standard aggregate data to providers and counties. The IM Trend and Quality Performance Reports are sources of relevant data for Incident Management/Risk Management/Quality Management Committee meetings at provider, county, and statewide levels.

Delivery of the IM Data:

The delivery process of IM Trend and Quality Performance Reports for providers and counties are outlined in the referenced bulletin. Providers can access the reports via HCSIS and counties can access their reports via the Data Warehouse. The IM Trend and Quality Performance Reports will be delivered on a quarterly basis (based on calendar year). The Reports will encompass the last five quarters of data from the date the reports are received. These reports include the following:

Five Data Summary Reports:

1. Incident Management Data Summary
2. Incident Management Data Summary for Provider Compared to Statewide Data
3. Incident Management Investigation Data Summary

4. Incident Management Investigation Data Summary Compared to Statewide Data
5. Incident Management Milestone Data Summary

Two QM Core Performance Reports:

1. Reduction in Incidents for Providers (Restraints)
2. Reduction in Repeat Occurrences of Incidents for Unique Individuals for Providers

Template:

Also, a template has been developed that creates a standardized format for the completion of the Provider and County IM Analysis Report. The template is used to assist in:

- Converting incident and investigation data into information.
- Analyzing aggregate data.
- Identifying systemic issues derived from the aggregate analysis.
- Identifying preventative initiatives to reduce risk of recurrence.
- Identifying quality recommendations and strategies to promote the continued effort to ensure the health, welfare, and rights of people receiving supports and services.

The IM Analysis Report template has a list of “Questions for Consideration.” These questions are to be used as guidelines in the development of the IM Analysis Report. In addition, the IM Analysis Report template describes the systemic quality improvement and prevention activities implemented to improve and enhance the health and safety of individuals being served.

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

ODP is the state agency responsible for the oversight of and response to critical incidents.

Within 24 hours of the submission of the first section of the incident report, both the designated AE and ODP Regional office staff review the incident to determine that appropriate actions to protect the individual occurred. After the provider submits the final section of the HCSIS incident report, the AE is to complete a management review within 30 days. The management review process will include a determination that:

- The appropriate action to protect the individual occurred,
- The incident categorization is correct,
- Certified investigation occurred if needed,
- Proper safeguards are in place,
- Corrective action in response to the incident has, or will, take place. After the administrative entity approves the incident report
- ODP regional office staff complete a management review within 30 days of the AE’s approval. The management review will include all of the above including the AE’s response to the incident.

Each regional office also reviews significant events during the Risk Management committee meetings which are held at least monthly. When identified technical assistance is provided to the AE or provider.

During the annual ISP meetings and quarterly review of waiver participants, in licensed settings, the incidents of waiver participants are reviewed by the ISP team.

Annually, ODP will complete an analysis of aggregate incident data and licensing data to identify patterns and trends statewide and regionally. Factors that put people at risk are identified and recommendations made to implement appropriate interventions and improvement activities. Information from these reports is shared with stakeholders, and ODP staff are responsible for follow through.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

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

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

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

The Department is clear on its mission to eliminate restraints as a response to challenging behaviors. Through multiple bulletins and regulations, ODP carries out this mission and has demonstrated its commitment to the Positive Practices Paradigm and Everyday Lives.

Use of Alternative Methods before Instituting Restraints/Seclusion.

ODP Bulletin 00-06-09, Elimination of Restraints through Positive Practice, asks providers “to pursue alternative strategies to the use of restraint”. For example, physical restraints are the only type of restraint permitted, but may only be used as a last resort safety measure when there is a threat to the health and safety of the individual or others, and only when less intrusive measures such as redirection, reflective listening, and other positive practices are ineffective in each situation. A physical restraint is a hands-on technique that lasts thirty seconds or more used to control acute, episodic behavior that restricts the movement or function of an individual or portion of the individual's body. Physical restraint is always a last resort emergency response to protect the individual's safety. Consequently, it is never used as a punishment, therapeutic technique or for staff convenience. The individual is immediately to be released from the restraint as soon as it is determined that the individual is no longer a risk to him/herself or others.

Additionally, regulations specifically state “every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures”. Seclusion is prohibited by regulation and in Bulletin 00-06-09. Seclusion is placing an individual in a locked room. A locked room includes a room with any type of engaged locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut. Mechanical and chemical restraints are also prohibited by Bulletin 00-06-09. A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

Additionally, after any type of restraint has been used, two means of review are pursued so the provider and Commonwealth can determine if the use of a restraint was unauthorized. The first is through the Positive Practices Approach of Debriefing. ODP Bulletin 00-06-09 describes how this process could identify if a restraint was unauthorized. Second, regulation requires a Restrictive Procedure Committee review and update of restraint procedure plans.

ODP Bulletin 00-06-09 states that “Individual and team involvement in a post-restraint debriefing is critical to determine how future situations can be prevented. It is important, as part of the ongoing planning process to review each occurrence of restraint. Information from the debriefing sessions should, at minimum, be included in the Supports Coordinator monitoring update. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes to the individual's plan shall be documented in the ISP.”

Licensing regulations for licensed residential services and adult training facilities spell out requirements related to restrictive procedures. These regulations require that these licensed providers establish a restrictive procedure review committee, generally as per the regulatory requirements outlined below:

Restrictive procedure review committee

- (a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.
- (b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.
- (c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.
- (d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.

Detailed Documentation Regarding the Use of Restraints and Seclusion

All of these licensed providers must have written restraint policies. The regulations also require a restrictive procedure plan be written prior to the use of any restraint and only to ensure the health and safety of an individual. The only exception to using a restraint without a restraint procedure plan is when the restraint is used in an emergency to protect the health and safety of an individual. Compliance with regulations is reviewed as part of annual ODP licensing inspections. Bulletin 00-06-09 supports regulations and provides additional clarification on restraint documentation. Additionally,

Bulletin 00-06-11 Provider and County Incident Management Analysis Report outlines how the Commonwealth tracks incidents, and creates a Performance Report specifically on restraints.

Restraint, as a behavior modification technique or any use other than to protect health and safety, should not be incorporated as part of any ISP or as the method for modifying and/or eliminating behavior in a behavior plan.

It is recommended that all Providers develop agency-wide policies and procedures for the reduction and eventual elimination of restraint. These policies and procedures should outline the specific steps to be taken for the elimination of restraint components in any individual plan as well as general policies and procedures promoting the goal of restraint elimination.

Education and Training Requirements for Personnel who Administer Restraints and Seclusion

Education and training are key components to ODP's plan to reduce and eliminate restraints across the Commonwealth. Bulletin 00-06-09 outlines recommended curriculum content and training timeframes. It also frames training requirements for targeted staff. Specific sections of the residential and adult training regulations identify mandatory training requirements for personnel regarding restraints. Additionally, ODP has several resources available to providers to educate and train staff regarding the safe use of restraint and reduction and elimination of the necessity to use restraint.

The following training and education resources are available to providers:

- ODP (via web-cast)
- Health Care Quality Units
- ODP Consultants
- The Pennsylvania Training Partnership for People with Disabilities and Families
- In- house Provider Agency and State Center staff curricula
- College of Direct Support (CDS) online training sessions
- Positive Practices Resource Team (PPRT) which is a cross program office initiative between ODP and OMHSAS (Office of Mental Health and Substance Abuse Services) to provide direct technical assistance, training and support to providers who are supporting individuals, including waiver participants, who are experiencing high restraint usage or who have significant behavioral challenges.

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

ODP is responsible for ongoing oversight of the use of restraints or seclusion. Restraints and seclusion are reviewed during annual inspections of licensed providers, and through ODP Regional Risk Management meetings (at least monthly). ODP also has established a Positive Practices Review Team that is responsible for ongoing review of restraints and restraint elimination on both aggregate and individual levels. Policies are outlined in the Incident Management bulletin and in regulations. ODP's Deputy Secretary must review and sign off on any waiver of restraint regulation. (The allowance for regulatory waivers is included in Department regulations.). Aggregate data analysis of restraint and seclusion information occurs concurrently with the analysis of incident data.

The AE is responsible for the oversight of restraint use at the local level. Aggregate data analysis of restraint and seclusion occurs, at least, on a semi-annual basis. The analysis report is then sent to the appropriate ODP regional office for review and feedback.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- b. **Use of Restrictive Interventions.** (*Select one*):

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

The following definitions and regulations are applicable to licensed providers, who are reviewed through annual ODP licensing inspections:

The use of aversive conditioning, defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

Personal Funds and Property: (a) An individual's personal funds or property may not be used as reward or punishment. (b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages.

Appropriate use of restrictive procedures.

(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for the program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring restrictive procedures:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

Restrictive procedure review committee.

(a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.

Restrictive procedure plan.

(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the program specialist, the individual's direct care staff, the interdisciplinary team as appropriate and other professionals as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised, if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the program specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of restrictive procedures.

(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.

Restrictive procedure records.

A record of each use of a restrictive procedure documenting the specific behavior addressed, methods of intervention used

to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the staff person who used the restrictive procedure, the duration of the restrictive procedure, the staff person who observed the individual if exclusion was used and the individual's condition during and following the removal of the restrictive procedure shall be kept in the individual's record.

Informing and encouraging exercise of rights.

(a) Each individual, or the individual's parent, guardian or advocate, if appropriate, shall be informed of the individual's rights upon admission and annually thereafter.

(b) Statements signed and dated by the individual, or the individual's parent, guardian or advocate, if appropriate, acknowledging receipt of the information on rights upon admission and annually thereafter, shall be kept.

(c) Each individual shall be encouraged to exercise his rights.

Rights.

An individual may not be deprived of rights.

Rights of the individual.

(a) An individual may not be neglected, abused, mistreated or subjected to corporal punishment.

(b) An individual may not be required to participate in research projects.

(c) An individual has the right to manage personal financial affairs.

(d) An individual has the right to participate in program planning that affects the individual.

(e) An individual has the right to privacy in bedrooms, bathrooms and during personal care.

(f) An individual has the right to receive, purchase, have and use personal property.

(g) An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with family and persons of the individual's own choice.

(h) An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary

(i) An individual has the right to unrestricted mailing privileges.

(j) An individual who is of voting age shall be informed of the right to vote and shall be assisted to register and vote in elections.

(k) An individual has the right to practice the religion or faith of the individual's choice.

(l) An individual has the right to be free from excessive medication.

(m) An individual may not be required to work at the home, except for the upkeep of the individual's personal living areas and the upkeep of common living areas and grounds.

Civil rights.

(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) The home shall develop and implement civil rights policies and procedures. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, use of the home, referrals and communication with non-English speaking and nonverbal individuals.

(2) Physical accessibility and accommodations for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals of their right to register civil rights complaints

In addition to the laws, regulations and policies to assure safety related to restraint and seclusion, ODP has initiated statewide activities such as Positive Approaches and participates in the Department of Public Welfare's initiative to reduce restraint applications.

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

All restrictive interventions are clearly defined and outlined in ODP's regulations. During their annual reviews, licensing staff are responsible for reviewing incidents during which restrictive interventions were used as well as any restrictive procedure plans that may be in place. Additionally, ODP has issued a bulletin which outlines the policies and procedures for Incident Management.

ODP Regional risk management committees meet at least monthly and monitor the incidence of restraint applications and share findings and analysis with the statewide Positive Practices Resource Team (PPRT). The PPRT reviews that appropriate services and supports are in place for individuals experiencing restraint applications.

The Statewide ODP Risk Management Workgroup is charged with completing analysis of statewide incident data. This Workgroup is comprised of ODP Regional Risk Managers, the ODP Central Office Risk Management Director, and the ODP Area Quality Management leads. The Workgroup has completed analysis of fiscal year 2004/2005 incident data, and compiled a statewide Incident Management report based on this review. The report will serve as ODP's baseline for incident analysis. Recommendations from the Statewide Risk Management Workgroup will be proposed to ODP Leadership and ultimately implemented statewide. ODP Regional Offices will develop action plans to address the

recommendations to promote systems change.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

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

Supports Coordinators review medication regimens for individuals during face-to-face monitoring visits using a standard ISP monitoring tool.

They can use Health Care Quality Units (HCQUs) for support with regard to questions about medications. Nurses from the Health Care Quality Units (HCQUs) review medications for a random sample of individuals across the state every year. As part of the Health Risk Profile and individual case reviews, the HCQU will review the records, provide training and answer questions.

ODP licensing reviews medication information when conducting standard annual reviews for licensed providers. This includes review of medication practices, logs, storage, etc.

Through its regional offices, ODP monitors AE's by reviewing a sample of individual records including the medications that people take. The AE's have access to nurses who help with questions about medications and responses.

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

Through the Office of Medical Assistance Programs each participant's medications are reviewed at the time of refill or addition of a new medication via a standard pharmacy program to look for problems like therapeutic duplication, prescribed allergic medications, dosages over the recommended level, concurrent use of contraindicated medications, etc. The pharmacist contacts the prescribing practitioner if a potential problem before filling the prescription.

This information is reviewed through a Drug Utilization Review both prospectively and retrospectively and findings are communicated to healthcare practitioners either collectively thru Continued Medical Education (CME) or individually. In addition to the pharmacist contacting the prescribing practitioner, patterns of potentially harmful practices are communicated to the practitioner community via remittance advices and CME addressing the particular issue. In addition, nurses from the Health Care Quality Units (HCQUs) review medications for a random sample of individuals across the state every year. They address issues for individuals directly with the provider and use patterns to develop educational materials and training about those issues. Follow-up occurs in multiple ways including directly from the HCQU, the AE, or ODP. Licensing reviews bring problematic patterns about medication administration practices to a central level and then they are addressed either directly with a provider or incorporated into the medication administration training course. Follow-up of these findings occur through the regional offices of ODP. Information about best practices and potentially harmful new drug information is communicated to the field via Drug Alerts. Direct consultation with a pharmacist with a specialty certification in psychiatric pharmacology occurs on an as needed basis.

Appendix G: Participant Safeguards

c. Medication Administration by Waiver Providers

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

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

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

State regulations for community homes and day programs allow for the administration of medication by unlicensed staff when trained using a standard Medication Administration course. The current medication administration course requires the review of medication administration logs for errors in documentation including matching the person’s prescribed medications on the log to those available to be given. Observation of medication passes are required on an annual basis. Clinical nursing staff are not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self administration guidelines appear in the regulations and setting up and monitoring self administration programs are taught as part of the medication administration program. These requirements do not apply to non-licensed providers.

Medications are also monitored by supports coordinators as part of their routine monitoring of licensed and unlicensed waiver services.

The autonomy of individuals who have the capacity to make health care decisions is respected, and decisions made by competent individuals are honored. Competency is determined by the involved physician. If an individual is not competent to make a particular decision, another person must make the decision on the individual’s behalf. When necessary, surrogate decision makers should be chosen in the following order:

1. A health care agent.
2. A guardian of the individual.
3. A health care representative.
4. The administrative head of a provider agency.

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The Department of Public Welfare, Office of Developmental Programs via an electronic database, HCSIS which is accessible by the state, AE’s and providers.

(b) Specify the types of medication errors that providers are required to *record*:

See below

(c) Specify the types of medication errors that providers must *report* to the State:

Providers report medication errors as specified in the Incident Management module of HCSIS including wrong person, wrong medication (wrong medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

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

ODP monitors performance of providers with regard to medication administration through multiple mechanisms. Each AE is monitored by reviewing a sample of people in the waiver including reviewing their medications. Annual licensing inspections monitor medication administration through standardized reviews of licensed services. AE's and supports coordinators monitor medications for individuals. Health Care Quality Units (HCQUs) provide training and technical assistance to providers on an on-going basis to promote the use of best practices around medication administration. They review the medications of a random sample of people over a year's time.

The required medication administration course teaches problem solving and has been modified to address problems identified through data captured in HCSIS. The HCQU's, AE's, and regional risk management committees review medication errors on a regular basis. ODP reviews reports submitted by the AE. The AE review reports submitted by providers. Any medication error leading to hospitalization, emergency room visit, etc. is reviewed in depth with the potential for investigation. ODP reviews lead to changes in the medication administration instrument and additional training. Currently ODP is developing training related to best practices. Health Alerts are issued and distributed widely on specific drugs issues.

Appendix H: Quality Management Strategy (1 of 2)

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

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

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

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

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

Quality Management Strategy: Minimum Components

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

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;

- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

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

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:

Attachment #1 to Appendix H

Quality Management Strategy for Consolidated (#0147) and Person/Family Directed Support (#0354) Waivers

ODP is committed to complying with waiver assurances, ensuring the health and safety of people receiving services, implementing promising practices, and offering the highest quality services that promote choice and control in people's everyday lives.

ODP continuously strives to improve the quality of services and supports through:

- Guidance from people who receive services and supports and their families
- Recommendations from the Planning Advisory Committee (PAC), and
- Collaboration with all partners – advocates, providers, administrative entities, and the community.

The approach ODP uses to lead the system in promoting the core value of Everyday Lives is a quality management strategy. ODP views quality management as a planned, systemic and organization-wide approach to data collection and analysis, performance measurement, and continuous improvement. Quality is built in throughout processes; it has four interrelated aspects:

1. Compliance with CMS Waiver Assurances;
2. Systemically collecting and analyzing data;
3. Designing initiatives; and
4. Monitoring results for sustainability or need for improvement.

PLEASE SEE THE ADDENDUM TO APPENDIX H, WHICH OUTLINES THE ODP QUALITY MANAGEMENT OVERSIGHT ACTIVITIES BASED ON THE CMS ASSURANCES.

H2: Roles and Responsibilities

Management Structure, Roles and Responsibilities

ODP Leadership Board

- Oversees and monitors all processes and functions related to the Quality Management Strategy in the mental retardation service system
- Establishes performance indicators that need to be assessed in the system
- Reviews and approves an Annual Plan and Report
- Reviews statewide performance outcomes, trends and patterns.
- Determines quality improvement actions based on the review of information
- Evaluates the effectiveness of organization-wide quality improvement activities
- Approves recommendations for policies, regulations, practices, and training

ODP Central Office Waiver Assurance Oversight Group

- Reviews statewide performance outcomes, trends and patterns
- Identifies practices to be adopted (promising practices), modified, or eliminated.
- Recommends training that will embed desired policies and practices.
- Recommends changes/revisions/additions to policies, procedures and practices, Bulletins, Waivers (Consolidated and P/FDS), and regulations.
- Evaluates the effectiveness of implemented policies and practices and statewide training.

- Evaluates the usefulness of the data sources used to measure system performance and recommend enhancements.

ODP Regional Office Waiver Assurance Oversight Group

- Reviews regional performance outcomes, trends and patterns
- Reviews data to determine compliance with waiver assurances
- Recommends practices to be adopted (promising practices), modified, or eliminated
- Approves remediation plans
- Monitors progress on remediation plans

Administrative Entity

- Reviews administrative entity and provider performance outcomes, trends and patterns
- Develops, submits, and implements approved plans to address remediation
- Implements the new or modified practices or eliminates practices identified by the ODP Regional and Central Office groups

While not all quality structures will be the same, ODP expects that Administrative Entities and waiver providers will:

- Access and review data that is available on HCSIS and other sources (i.e. Data Warehouse)
- Develop an organizational capacity to analyze data for quality improvement purposes
- Collaborate with their service system partners in improving services and supports in their area
- Share quality information with partners and stakeholders

Planning Advisory Committee (PAC)(which includes participants, family members, and advocacy organizations)

- Provides input on priorities to be included in the Annual Plan
- Reviews Annual Report and provides advice to address areas of deficiency noted.
- Establishes workgroups, as needed, to study particular areas of concern; recommend plans of action and review follow up information regarding implementation of those plans.

H3: Process to Establish Priorities and Develop Strategies for Improvement

Since numerous areas may exist where improvement activities are warranted, priorities must be determined. In assigning priorities the ODP Leadership Board will consider the following factors:

1. High risk: measures relating to activities, procedures, and behaviors having the potential to harm or injure.
2. Self-determination: areas where choice and control are affected.
3. System mandated: areas that must comply with local, state or federal; policies and regulations, including waiver requirements and assurances.

At each level of the Quality Management Structure, an evaluation of data will be used to determine compliance with waiver assurances. For areas of non-compliance identified by ODP, the administrative entity must develop and submit a plan of correction. The ODP Regional Oversight Group will approve the plan and monitor progress of corrective actions. The ODP Central Office Group and Leadership Board will review statewide compliance data and monitor corrective actions on an aggregate basis.

Through evaluation of data, the ODP Central Office Group will identify practices to be adopted, modified or eliminated. They will also recommend training that will embed desired policies and practices and changes/revisions to policies, procedures and practices. The ODP Leadership Board will approve implementation of the recommendations for training, policy and practice changes.

H4: Process to Compile Information and Communicate to Stakeholders

Compilation of Information

For specific information on each waiver assurance, reference H1.

The Quality Management Annual Plan is ODP's method for measuring and influencing quality through the achievement of performance outcomes. The Annual Plan will include:

- The Waiver Assurances
- Performance Outcomes for each assurance
- Performance Measures including data sources and responsible persons

The methodology for the Annual Plan includes a continuous improvement process, a cycle of assessment, analysis and action for improvement.

All information management processes in ODP follow the same seven steps:

Step 1 - Plan and organize for data collection, interpretation and use.

Step 2 - Verify data and ensure corrections are made as needed.

Step 3 - Identify and present potentially important findings (What is the trend over time? How are the data likely to be interpreted or misinterpreted? Is there an opportunity for improvement? Who should receive the data and for what purpose?).

Step 4 - Study and analyze the data further to develop recommendations for change. The analysis will include variation analysis, review of additional data, process analysis, and/or focused review.

Step 5 - Take action to improve care and/or services through training, technical assistance, and/or changes in policies/practices.

Step 6 - Monitor performance for the impact and effectiveness of the quality improvement actions that were implemented.

Step 7 - Communicate results to ODP staff and stakeholders.

Communication of Quality Management Information to Stakeholders

The PAC is a stakeholder group comprised of consumers, families, advocates, providers and administrative entities. ODP will solicit recommendations from the PAC for outcomes to be included in the Annual Plan. On a yearly basis, the results of the Annual Plan will be presented to the PAC.

The Annual Plan and Annual Report will be posted on the ODP website for access by all stakeholders.

H5: Process for Evaluation and Revision of the Quality Management Strategy

On an annual basis, the ODP Leadership Board will assess compliance with Waiver Assurances. The results of assessing performance outcomes may demonstrate the need to revise ODP's Quality Management Strategy including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities and modifying data sources in order to retrieve the information needed for measurement. Progress on the Quality Management activities, as well as any major changes to the Strategy will be communicated to CMS as part of the CMS annual report submission.

PLEASE SEE THE ADDENDUM TO APPENDIX H, WHICH INCLUDES THE ODP DETAILED WORK PLAN RELATED TO THE CONSOLIDATED AND PERSON/FAMILY DIRECTED SUPPORT WAIVERS.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

The method employed to assure the integrity of payments made for waiver services is to conduct an annual fiscal year audit of state government, AE's, and for profit and nonprofit organizations in compliance with the requirements of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156. Pennsylvania's 4300 regulations require that all subrecipients (profit and nonprofit) have an annual audit conducted in accordance with Generally Accepted Governmental Auditing Standards (GAGAS). If the subrecipient is a nonprofit and meets the thresholds, a Single Audit is required. If the subrecipient is a for-profit entity expending \$500,000 or more in federal Department of Health and Human Services funding, the entity has the option to either have an annual Single Audit or a program specific audit conducted in accordance with GAGAS.

The Department of the Auditor General, an independent office, and the fiscal "watchdog" of Pennsylvania taxpayers conducts the annual state fiscal year, Commonwealth of Pennsylvania Single Audit. The Office of Management and Budget (OMB) Circular No. A-133 issued pursuant to the Single Audit Act as amended, sets forth standards for obtaining consistency and uniformity for the audit of States, local governments, and non-profit organizations expending Federal awards. Additionally, the A-133 Compliance Supplement based on the requirements of the 1996 Amendments and 1997 revisions to OMB Circular A-133, provides for the issuance of a compliance supplement to assist auditors in performing the required audits. The guidelines presented in the compliance supplement are the basis for the financial and compliance testing of waiver services.

Subrecipients of Federal awards such as County governments (local governments) and non-profit providers of service are audited annually in accordance with the Single Audit Act, as amended. County government audits are conducted by contracting with certified public accounting (CPA) firms, or by independently elected County controllers. Non-profit providers of service are audited exclusively

by contracting with CPA firms. The Department of Public Welfare (DPW) releases an annual Single Audit Supplement publication to County government and CPA firms which provides compliance requirements specific to DPW programs, including waiver services, at the local government level. The waiver services are tested in accordance with the compliance requirements contained in the Supplement.

The purpose of the Single Audit Supplement is to fill four basic needs: 1) a reference manual detailing additional financial and compliance requirements pertaining to specific DPW programs operated by local governments and/or private agencies; 2) an audit requirement to be referenced when contracting for single audit services, providing the auditing entity with the assurance that the final report package will be acceptable to the DPW; 3) a vehicle for passing compliance requirements to a lower tier agency; 4) additional guidance to be used in conjunction with Single Audit as amended, OMB Circular A-133, Government Auditing Standards (commonly know as the Yellow Book) issued by the Comptroller General of the United States; OMB Federal Compliance Supplement, and audit and accounting guidance issued by the AICPA.

The DPW will be implementing an Audit Requirements and Guidelines document which will supplement the Provider's independent audit and require additional disclosure for rate setting information and high risk areas. The audit document will be effective for audit periods beginning July 1, 2008, and will be a compliance requirement in all waiver provider contracts.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

The County Mental Health/Mental Retardation Fiscal Manual (Title 55, Chapter 4300 of the Pennsylvania Code) establishes the requirements for paying providers. The Mental Health/Mental Retardation Act of 1966 and the 4300 regulations allow services to be provided by AE's directly or by private providers. The AE's serve as the fiscal agent of ODP to pay private providers. When serving as fiscal agents of ODP, the AE's are responsible for rate determination. There is no requirement for public comment in the process.

AE's are subject to the requirements of the federal Single Audit Act and the resolution of these audits is coordinated by the Bureau of Financial Operations (BFO). BFO and the Comptroller's Office undertake requests by ODP for special audits. BFO is involved with financial reporting, financial policy, and audit policy of the MR program. In the future, claims will be processed through PROMISE which is administered by the Office of Medical Assistance Programs (OMAP) and the Department of Public Welfare Bureau of Information Systems (BIS).

When AE's provide services directly, sections 4300.41 to 4300.69 of the 4300 regulations establish the allowable cost standards upon which reimbursement of costs may be claimed. Reconciliation (cost settlement) to actual, allowable costs occurs at the end of the fiscal year.

AE's make payment to private providers on a unit of service basis.

Fee for service payments, which are payments that do not involve cost reconciliation, only occur under limited circumstances. These include waivers of the regulations in response to Administrative Entity requests to make true fee for service payments, when the Department of Public Welfare establishes fees by publishing service rates (section 4300.115), or when ODP is not funding the majority of the provider's clients (section 4300.114). For all other situations, rates are cost-based and involve cost reconciliation as the end of the fiscal year.

ODP is transitioning from a decentralized rate setting approach to a standardized rate setting approach. ODP distributed a rate setting bulletin and guidelines that was used to establish rates during FY's 2006-2007 and 2007-2008, and will be used to establish rates for FY 2008-2009 (transition years).

Rates are established using rate setting guidelines and instructions, including allowable cost standards, through the completion of standardized rate setting spreadsheets. Waiver providers complete the spreadsheets based on the guidelines and instructions and submit them to Administrative Entities. Administrative Entities review the spreadsheets to ensure that providers have completed them based on ODP guidelines and requirements. Administrative Entities may not set additional rate setting requirements on waiver providers. ODP monitors compliance with the rate setting methodology and process through its AE Oversight and provider dispute

resolution protocol.

During the transition period, (FY's 2006-2007, 2007-2008, and 2008-2009), ODP is conducting an analysis of rates that are developed using the standardized rate setting methodology and process. ODP is making adjustments to the methodology and process based on this analysis. ODP will also make adjustments to service definitions and units and will establish or revise rate setting policies and regulations based on the analysis. ODP expects that over time the analysis may result in some services being funded through true fee-for-service, and others through a cost-based. ODP is also reviewing the rate setting process through its oversight of Administrative Entities.

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

ODP has established a rollout plan to move towards direct provider billing to PROMISE. The rollout plan involves three "waves". In fiscal year 2006/2007, providers who contract with "Wave 1" AE's, and most providers who contract with "Wave 2" AE's began to invoice through PROMISE. All other "Wave 2" providers and "Wave 3" providers continued invoicing the AE's directly during fiscal year 2006/2007. "Wave 3" providers began to roll into PROMISE billing beginning in July 2007. All waiver providers, with the exception qualified support service workers and vendors providing services through an ISO, will bill PROMISE directly and be paid through the Pennsylvania Treasury by July 2009. Agency with Choice ISO's and the statewide Vendor Fiscal ISO will bill PROMISE directly for services by July 2009.

"Wave 1" involves Berks, Dauphin, Delaware, and Westmoreland Counties.

"Wave 2" involves Allegheny, Blair, Bradford/Sullivan, Butler, Clearfield/Jefferson, Cumberland/Perry, Erie, Forest/Warren, Lebanon, Mercer, Northumberland, Philadelphia, Schuylkill, and Venango Counties.

"Wave 3" involves Armstrong/Indiana, Beaver, Bedford/Somerset, Bucks, Cambria, Cameron/Elk, Carbon/Monroe/Pike, Centre, Chester, Clarion, Columbia/Montour/Snyder/Union, Crawford, Fayette, Franklin/Fulton, Greene, Huntingdon/Mifflin/Juniata, Lackawanna/Susquehanna, Lancaster, Lawrence, Lehigh, Luzerne/Wyoming, Lycoming/Clinton, McKean, Montgomery, Northampton, Potter, Tioga, Washington, Wayne, and York/Adams Counties.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. Public agencies do not certify expenditures for waiver services.**
- Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Non-State Public Agencies.**

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

Provider billings are verified either through the PROMISE system or by the AE if they are not participating in the PROMISE pilot project. PROMISE includes edits to determine if the individual is eligible for Medicaid payment on the date of service and ensure that the service was part of the individual's plan. The service is approved for payment by PROMISE only if the service is authorized and there are sufficient units available on the individual's support plan. For those AE's not participating in the PROMISE pilot project, the AE reviews and validates the payment. Validation that the service has been provided occurs through the audit process at the end of the year.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

ODP has established a rollout plan to move towards direct provider billing through PROMISE (see I-2-b). Providers not billing through PROMISE will continue billing to and receiving payments from the AE's. Those billing PROMISE will utilize a PROMISE generated payment file to verify the payment has been checked against the individual's plan and authorize the AE to make payment. Quarterly expenditure reports from the AE's are sent to ODP and then summarized and sent to the comptroller to complete the actual claim for Federal Financial Participation. No payments are currently made directly from PROMISE. Payments for waiver services will be made directly through the Pennsylvania Treasury based on approved claims from PROMISE effective July 1, 2009.

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

AE's currently are the fiscal agents that make payments for all waiver services as per the requirements outlined in the current Administrative Entity Operating Agreement and the 4300 regulations. As the fiscal agent, the AE processes and pays claims for waiver services up to the amount of funds identified in the AE's financial commitment letter. If the funds identified in the financial commitment letter are projected or identified to be insufficient to meet the identified needs of waiver participants, including changes in need, the AE is responsible to immediately notify ODP.

The AE is responsible to ensure that waiver funding is not used to purchase ineligible waiver services; services to ineligible persons; or services provided by providers ineligible to render waiver services.

The AE is responsible to authorize funds to provide waiver services. The AE shall ensure that waiver funding is not authorized until the waiver participant has been determined eligible for services; the waiver participant has exercised freedom of choice; an individual support plan that addresses the identified needs of the waiver participant has been developed; the services included in the plan have been determined necessary to meet the identified needs; and providers in the plan have been qualified as waiver providers.

The AE must ensure that all payments to waiver providers are made in accordance with Title 42, CFR Part 447. The AE is responsible to conduct a prepayment review of all waiver claims.

ODP oversees the performance of AE's related to the payment of waiver services through a variety of mechanisms, including AE Oversight, provider dispute resolution, review and investigation of complaints, review of financial reports, and review of HCSIS data.

ODP is moving towards direct payment of waiver provider services, with an anticipated timeline of July 1, 2009.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

- No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish:
Complete item I-3-e.

AE's can receive payment for any waiver service. Only two AE's provide direct waiver services, and one of these provide minimal services. These two AE's were required to submit a detailed proposal to ODP that described the administrative procedures that are in place to ensure that individuals have free choice of willing and qualified providers and of conflict-free supports coordination services. The proposals also outlined steps the AE is taking to transfer service provision to other qualified providers. Proposals are subject to approval by ODP.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to Public Providers.

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

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

Describe the recoupment process:

Cost settlement (reconciliation) occurs at the end of the fiscal year based on actual, allowable costs as defined by the Title 4300 regulations. Any excess funds (carryover) are adjusted against subsequent payments to reduce those payments. The reports used to claim federal funds are adjusted to reflect cost settlement.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s)

for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

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

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal

share of computable waiver costs that are not from state sources. *Select One:*

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

Check each that applies:

- Appropriation of Local Revenues.**

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

- Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**

Check each that applies:

- Provider taxes or fees**
- Provider donations**
- Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology

that the State uses to exclude Medicaid payment for room and board in residential settings:

In the event of differences between the Federal and State regulations, the Pennsylvania Department of Public Welfare, Office of Developmental Programs will follow Federal rules and interpretations regarding the scope of what may and may not be claimed in accordance with the exclusion of room and board. The State assures CMS that payments are not made for room and board except as explicitly allowed in 42 CFR § 441.310 (a) (2), which permits room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence. Room and board costs are excluded from respite services when the service is provided in a setting that is not facility-based.

The ODP/AE Operating Agreement requires AE's to utilize ODP's rate setting methodology to set rates for waiver services. This includes the use of standardized rate setting spreadsheets and guidelines, developed by ODP, to set rates for waiver services. The standard spreadsheet for residential services calculates both waiver eligible and ineligible costs. The residential rate setting spreadsheet is formatted to allow room and board costs to be entered as part of the ineligible costs only; room and board costs cannot be entered as part of eligible costs on the spreadsheet. Completion of the spreadsheet results in an eligible rate and an ineligible rate.

Providers complete spreadsheets for the services they provide, and submit them to the AE. The AE is responsible to ensure that spreadsheets have been completed as per ODP's rate setting methodology. ODP is conducting an analysis of rates, based on a sample of completed spreadsheets. In addition, the new AE Oversight by ODP, which began in April 2007, will include a review of completed spreadsheets for a sample of providers to ensure compliance with the statewide rate setting methodology. Provider audits display the breakdown of eligible and ineligible costs. These audits are reviewed by AE's to ensure compliance with applicable policies and regulations.

Appendix I: Financial Accountability

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

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

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

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*
 - No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
 - Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. Co-Pay Arrangement.**

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

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
 - ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
 - iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
 - iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	76890.68	9668.00	86558.68	131219.00	6431.00	137650.00	51091.32
2	78124.37	9861.00	87985.37	133843.00	6560.00	140403.00	52417.63
3	78238.87	10058.00	88296.87	136520.00	6691.00	143211.00	54914.13
4	79687.18	10259.00	89946.18	139250.00	6825.00	146075.00	56128.82
5	81280.59	10464.00	91744.59	142035.00	6962.00	148997.00	57252.41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/MR	
Year 1	16942		16942
Year 2	17559		17559
Year 3	17619		17619
Year 4 (renewal only)	17646		17646
Year 5 (renewal only)	17646		

Appendix J: Cost Neutrality Demonstration

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

The average length of stay is determined by dividing the total days of coverage by the number of unduplicated recipients. The current average length of stay is 342 days.

Estimates of Factor D (J-2-d) are calculated through the extrapolation of current PROMISE claims data.

Service definitions are being amended July 1, 2009, and the new services are reflected in the Appendix J estimates charts. For new services, waiver years one and two on the charts shows \$0.00 for expenditures. One service, Permanency Planning Services, was deleted, and has therefore been removed from the charts.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

The Factor D is the average per capita cost for waiver recipients.

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

The Factor D' is the average per capita costs for acute care services used by waiver participants, excluding Medicare Part D costs.

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

Factor G is the average per capita cost for acute care services used by ICF/MR recipients.

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

Factor G' is the estimated average per capita cost for ICF/MR recipients who are not receiving waiver services but are using acute care services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Nursing
Respite
Companion
Transportation
Supported Employment - Job Finding and Job Support
Assistive Technology
Specialized Supplies

Supports Coordination
Homemaker/Chore
Prevocational Services
Residential Habilitation
Home Finding
Transitional Work Services
Home and Community Habilitation
Therapy Services
Licensed Day Habilitation
Home Accessibility Adaptations
Behavioral Support
Vehicle Accessibility Adaptations
Education Support Services
Supports Broker Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8310483.72
Nursing	Quarter Hour	198	4123.00	10.18	8310483.72	
Respite Total:						9421936.28
15-Minute Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 1	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 1	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 2	N/A	0	0.00	0.01	0.00	

24-Hour Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Temporary Respite	Quarter Hour	1541	1086.00	4.38	7330043.88	
Overnight Respite	Day	806	10.00	259.54	2091892.40	
Companion Total:						0.00
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Transportation Total:						16337138.50
Transportation (Mile)	Mile	326	833.00	0.50	135779.00	
Transportation (Trip)	Trip	6262	131.00	19.75	16201359.50	
Transportation (Per Diem)	N/A	0	0.00	0.01	0.00	
Public Transportation	N/A	0	0.00	0.01	0.00	
Supported Employment - Job Finding and Job Support Total:						1379761.25
Job Finding	N/A	0	0.00	0.01	0.00	
Job Support	N/A	0	0.00	0.01	0.00	
Supported Employment	Quarter Hour	875	137.00	11.51	1379761.25	
Assistive Technology Total:						221554.20
Assistive Technology	Year	357	5.00	124.12	221554.20	
Specialized Supplies Total:						0.00
Specialized Supplies	N/A	0	0.00	0.01	0.00	
Supports Coordination Total:						41601081.00
Supports Coordination	Quarter Hour	16942	150.00	16.37	41601081.00	
Homemaker/Chore Total:						795063.28
Homemaker/Chore	Hour	818	94.00	10.34	795063.28	
Prevocational Services Total:						39232300.80
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	

Level 3	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Prevocational Services	Quarter Hour	6690	3136.00	1.87	39232300.80	
Residential Habilitation Total:						951989667.07
CH 3800, Child Residential Services	N/A	0	0.00	0.01	0.00	
CH 5310, Community Residential Rehabilitation Services	N/A	0	0.00	0.01	0.00	
CH 6400, Community Homes	N/A	0	0.00	0.01	0.00	
CH 6500, Family Living	N/A	0	0.00	0.01	0.00	
Unlicensed Community Homes	N/A	0	0.00	0.01	0.00	
Unlicensed Family Living	N/A	0	0.00	0.01	0.00	
Residential Habilitation	1/2 Month	11183	23.00	3701.23	951989667.07	
Home Finding Total:						134028.00
Home Finding	Quarter Hour	54	200.00	12.41	134028.00	
Transitional Work Services Total:						1689345.00
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Transitional Work Services	Quarter Hour	700	465.00	5.19	1689345.00	
Home and Community Habilitation Total:						133777730.65
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation	Quarter Hour	4360	2590.00	6.65	75094460.00	
Unlicensed Residential	1/2 Month	811	23.00	3146.05	58683270.65	

Therapy Services Total:						1899771.96
Physical Therapy	Quarter Hour	353	103.00	15.50	563564.50	
Occupational Therapy	Quarter Hour	311	10.00	16.42	51066.20	
Speech/Language Therapy	Quarter Hour	57	58.00	16.35	54053.10	
Visual/Mobility Therapy	Quarter Hour	28	489.00	15.00	205380.00	
Behavior Therapy	Quarter Hour	1767	32.00	18.14	1025708.16	
Licensed Day Habilitation Total:						87301120.00
Basic Staff Support (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 1 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 2 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 3 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 4 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Older Adult Day	N/A	0	0.00	0.01	0.00	
Licensed Day Habilitation	Quarter Hour	8024	3200.00	3.40	87301120.00	
Home Accessibility Adaptations Total:						6573396.80
Home Accessibility Adaptations	Year	1360	1.00	4833.38	6573396.80	
Behavioral Support Total:						0.00
Behavioral Support	N/A	0	0.00	0.01	0.00	
Vehicle Accessibility Adaptations Total:						0.00
Vehicle Accessibility Adaptations	N/A	0	0.00	0.01	0.00	
Education Support Services Total:						496162.22
Education Support Services	Year	163	1.00	3043.94	496162.22	
Supports Broker Services Total:						1521437.58
Supports Broker Services	Quarter Hour	3141	78.00	6.21	1521437.58	
GRAND TOTAL:						1302681978.31
Total Estimated Unduplicated Participants:						16942
Factor D (Divide total by number of participants):						76890.68
Average Length of Stay on the Waiver:						342

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8800994.40
Nursing	Quarter Hour	205	4136.00	10.38	8800994.40	
Respite Total:						9963004.24
15-Minute Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 1	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 1	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 2	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Temporary Respite	Quarter Hour	1597	1086.00	4.47	7752508.74	
Overnight Respite	Day	835	10.00	264.73	2210495.50	
Companion Total:						0.00
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Transportation Total:						17269234.68
Transportation (Mile)	Mile	338	833.00	0.52	146408.08	
Transportation (Trip)	Trip	6490	131.00	20.14	17122826.60	
Transportation (Per Diem)					0.00	

	N/A	0	0.00	0.01		
Public Transportation	N/A	0	0.00	0.01	0.00	
Supported Employment - Job Finding and Job Support Total:						1458800.66
Job Finding	N/A	0	0.00	0.01	0.00	
Job Support	N/A	0	0.00	0.01	0.00	
Supported Employment	Quarter Hour	907	137.00	11.74	1458800.66	
Assistive Technology Total:						234210.00
Assistive Technology	Year	370	5.00	126.60	234210.00	
Specialized Supplies Total:						0.00
Specialized Supplies	N/A	0	0.00	0.01	0.00	
Supports Coordination Total:						43985295.00
Supports Coordination	Quarter Hour	17559	150.00	16.70	43985295.00	
Homemaker/Chore Total:						840961.60
Homemaker/Chore	Hour	848	94.00	10.55	840961.60	
Prevocational Services Total:						41532995.84
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Prevocational Services	Quarter Hour	6934	3136.00	1.91	41532995.84	
Residential Habilitation Total:						1002808331.75
CH 3800, Child Residential Services	N/A	0	0.00	0.01	0.00	
CH 5310, Community Residential Rehabilitation Services	N/A	0	0.00	0.01	0.00	
CH 6400, Community Homes	N/A	0	0.00	0.01	0.00	
CH 6500, Family Living	N/A	0	0.00	0.01	0.00	
Unlicensed Community Homes	N/A	0	0.00	0.01	0.00	
Unlicensed Family Living	N/A	0	0.00	0.01	0.00	
Residential Habilitation	1/2 Month	11549	23.00	3775.25	1002808331.75	

Home Finding Total:						141792.00
Home Finding	Quarter Hour	56	200.00	12.66	141792.00	
Transitional Work Services Total:						1785851.10
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Transitional Work Services	Quarter Hour	726	465.00	5.29	1785851.10	
Home and Community Habilitation Total:						139526043.67
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation	Quarter Hour	4519	2528.00	6.78	77454936.96	
Unlicensed Residential	1/2 Month	841	23.00	3208.97	62071106.71	
Therapy Services Total:						2007940.64
Physical Therapy	Quarter Hour	366	103.00	15.81	596005.38	
Occupational Therapy	Quarter Hour	322	10.00	16.75	53935.00	
Speech/Language Therapy	Quarter Hour	59	58.00	16.68	57078.96	
Visual/Mobility Therapy	Quarter Hour	29	489.00	15.30	216969.30	
Behavior Therapy	Quarter Hour	1831	32.00	18.50	1083952.00	
Licensed Day Habilitation Total:						92351968.00
Basic Staff Support (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 1 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 2 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 3 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 4 (CH 2380)	N/A	0	0.00	0.01	0.00	

Level 4 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Older Adult Day	N/A	0	0.00	0.01	0.00	
Licensed Day Habilitation	Quarter Hour	8317	3200.00	3.47	92351968.00	
Home Accessibility Adaptations Total:						6946581.35
Home Accessibility Adaptations	Year	1409	1.00	4930.15	6946581.35	
Behavioral Support Total:						0.00
Behavioral Support	N/A	0	0.00	0.01	0.00	
Vehicle Accessibility Adaptations Total:						0.00
Vehicle Accessibility Adaptations	N/A	0	0.00	0.01	0.00	
Education Support Services Total:						524714.58
Education Support Services	Year	169	1.00	3104.82	524714.58	
Supports Broker Services Total:						1607123.70
Supports Broker Services	Quarter Hour	3255	78.00	6.33	1607123.70	
GRAND TOTAL:					1371785843.21	
Total Estimated Unduplicated Participants:					17559	
Factor D (Divide total by number of participants):					78124.37	
Average Length of Stay on the Waiver:						342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8573960.52
Nursing	Quarter Hour	201	4028.00	10.59	8573960.52	
Respite Total:						10234012.40
15-Minute Respite - Basic Staff Support	Quarter Hour	320	1385.00	2.75	1218800.00	
15-Minute Respite - Level 1	Quarter Hour	313	1180.00	3.00	1108020.00	
15-Minute Respite - Level 2	Quarter Hour	300	800.00	3.10	744000.00	

15-Minute Respite - Level 2 Enhanced	Quarter Hour	300	1200.00	5.47	1969200.00	
15-Minute Respite - Level 3	Quarter Hour	200	995.00	8.09	1609910.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	170	958.00	8.09	1317537.40	
24-Hour Respite - Basic Staff Support	Day	255	11.00	230.00	645150.00	
24-Hour Respite - Level 1	Day	243	11.00	235.00	628155.00	
24-Hour Respite - Level 2	Day	126	10.00	245.00	308700.00	
24-Hour Respite - Level 2 Enhanced	Day	86	10.00	297.00	255420.00	
24-Hour Respite - Level 3	Day	64	9.00	355.00	204480.00	
24-Hour Respite - Level 3 Enhanced	Day	64	9.00	390.00	224640.00	
Temporary Respite	N/A	0	0.00	0.01	0.00	
Overnight Respite	N/A	0	0.00	0.01	0.00	
Companion Total:						1242000.00
Basic Staff Support	Quarter Hour	60	1100.00	2.50	165000.00	
Level 1	Quarter Hour	60	1100.00	3.50	231000.00	
Level 2	Quarter Hour	70	900.00	4.00	252000.00	
Level 3	Quarter Hour	110	900.00	6.00	594000.00	
Transportation Total:						17347896.90
Transportation (Mile)	Mile	339	833.00	0.54	152488.98	
Transportation (Trip)	Trip	2860	180.00	28.00	14414400.00	
Transportation (Per Diem)	Day	350	120.00	27.00	1134000.00	
Public Transportation	Outcome Based	3303	92.00	5.42	1647007.92	
Supported Employment - Job Finding and Job Support Total:						1492299.90
Job Finding	Quarter Hour	455	137.00	11.97	746149.95	
Job Support	Quarter Hour	455	137.00	11.97	746149.95	
Supported Employment	N/A	0	0.00	0.01	0.00	
Assistive Technology Total:						241083.80
Assistive Technology	Year	85	1.00	2836.28	241083.80	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Supports Coordination Total:						45007735.50
Supports Coordination	Quarter Hour	17619	150.00	17.03	45007735.50	

Homemaker/Chore Total:						679375.20
Homemaker/Chore	Hour	742	40.00	22.89	679375.20	
Prevocational Services Total:						42587896.50
Basic Staff Support	Quarter Hour	2395	3249.00	1.70	13228303.50	
Level 1	Quarter Hour	1402	3200.00	1.80	8075520.00	
Level 2	Quarter Hour	800	3100.00	1.88	4662400.00	
Level 3	Quarter Hour	622	3100.00	1.89	3644298.00	
Level 3 Enhanced	Quarter Hour	604	3100.00	2.00	3744800.00	
Level 4	Quarter Hour	572	3100.00	2.50	4433000.00	
Level 4 Enhanced	Quarter Hour	563	3100.00	2.75	4799575.00	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Residential Habilitation Total:						1061256320.00
CH 3800, Child Residential Services	Day	100	320.00	300.00	9600000.00	
CH 5310, Community Residential Rehabilitation Services	Day	100	320.00	300.00	9600000.00	
CH 6400, Community Homes	Day	9398	320.00	281.00	845068160.00	
CH 6500, Family Living	Day	1500	320.00	236.00	113280000.00	
Unlicensed Community Homes	Day	600	320.00	290.00	55680000.00	
Unlicensed Family Living	Day	360	320.00	243.30	28028160.00	
Residential Habilitation	N/A	0	0.00	0.01	0.00	
Home Finding Total:						144592.00
Home Finding	Quarter Hour	56	200.00	12.91	144592.00	
Transitional Work Services Total:						1841205.40
Basic Staff Support	Quarter Hour	346	600.00	4.00	830400.00	
Level 1	Quarter Hour	258	580.00	5.06	757178.40	
Level 2	Quarter Hour	95	370.00	5.30	186295.00	
Level 3	Quarter Hour	30	310.00	7.24	67332.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation Total:						79779295.00
Basic Staff Support	Quarter Hour	890	3200.00	3.20	9113600.00	
Level 1	Quarter Hour	826	3000.00	3.95	9788100.00	
Level 2	Quarter Hour	800	2950.00	6.45	15222000.00	

Level 3	Quarter Hour	683	2900.00	6.85	13567795.00	
Level 3 Enhanced	Quarter Hour	500	2900.00	7.65	11092500.00	
Level 4	Quarter Hour	400	2830.00	9.98	11297360.00	
Level 4 Enhanced	Quarter Hour	350	2614.00	10.60	9697940.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Therapy Services Total:						2054362.38
Physical Therapy	Quarter Hour	367	103.00	16.13	609730.13	
Occupational Therapy	Quarter Hour	323	10.00	17.09	55200.70	
Speech/Language Therapy	Quarter Hour	59	58.00	17.01	58208.22	
Visual/Mobility Therapy	Quarter Hour	29	489.00	15.61	221365.41	
Behavior Therapy	Quarter Hour	1838	32.00	18.87	1109857.92	
Licensed Day Habilitation Total:						94815130.00
Basic Staff Support (CH 2380)	Quarter Hour	1328	3200.00	2.45	10411520.00	
Level 1 (CH 2380)	Quarter Hour	1064	3700.00	2.80	11023040.00	
Level 2 (CH 2380)	Quarter Hour	1028	3700.00	3.00	11410800.00	
Level 3 (CH 2380)	Quarter Hour	1000	3100.00	3.40	10540000.00	
Level 3 Enhanced (CH 2380)	Quarter Hour	913	2520.00	4.00	9203040.00	
Level 4 (CH 2380)	Quarter Hour	500	2620.00	5.00	6550000.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	485	3460.00	5.30	8893930.00	
Older Adult Day	Quarter Hour	2029	3300.00	4.00	26782800.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:						6255765.00
Home Accessibility Adaptations	Year	1244	1.00	5028.75	6255765.00	
Behavioral Support Total:						343296.00
Behavioral Support	Quarter Hour	447	64.00	12.00	343296.00	
Vehicle Accessibility Adaptations Total:						1866000.00
Vehicle Accessibility Adaptations	Year	1	311.00	6000.00	1866000.00	
Education Support Services Total:						535209.48
Education Support Services	Year	169	1.00	3166.92	535209.48	
Supports Broker Services Total:						2068272.36

Supports Broker Services	Quarter Hour	3267	98.00	6.46	2068272.36	
GRAND TOTAL:						1378490708.34
Total Estimated Unduplicated Participants:						17619
Factor D (Divide total by number of participants):						78238.87
Average Length of Stay on the Waiver:						342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8743982.40
Nursing	Quarter Hour	201	4028.00	10.80	8743982.40	
Respite Total:						10439993.30
15-Minute Respite - Basic Staff Support	Quarter Hour	320	1385.00	2.81	1245392.00	
15-Minute Respite - Level 1	Quarter Hour	313	1180.00	3.06	1130180.40	
15-Minute Respite - Level 2	Quarter Hour	300	800.00	3.16	758400.00	
15-Minute Respite - Level 2 Enhanced	Quarter Hour	300	1200.00	5.58	2008800.00	
15-Minute Respite - Level 3	Quarter Hour	200	995.00	8.25	1641750.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	170	958.00	8.25	1343595.00	
24-Hour Respite - Basic Staff Support	Day	255	11.00	234.60	658053.00	
24-Hour Respite - Level 1	Day	243	11.00	239.70	640718.10	
24-Hour Respite - Level 2	Day	126	10.00	249.90	314874.00	
24-Hour Respite - Level 2 Enhanced	Day	86	10.00	302.94	260528.40	
24-Hour Respite - Level 3	Day	64	9.00	362.10	208569.60	
24-Hour Respite - Level 3 Enhanced	Day	64	9.00	397.80	229132.80	
Temporary Respite	N/A	0	0.00	0.01	0.00	
Overnight Respite	N/A	0	0.00	0.01	0.00	
Companion Total:						1266840.00

Basic Staff Support	Quarter Hour	60	1100.00	2.55	168300.00	
Level 1	Quarter Hour	60	1100.00	3.57	235620.00	
Level 2	Quarter Hour	70	900.00	4.08	257040.00	
Level 3	Quarter Hour	110	900.00	6.12	605880.00	
Transportation Total:						17695115.13
Transportation (Mile)	Mile	339	833.00	0.55	155312.85	
Transportation (Trip)	Trip	2860	180.00	28.56	14702688.00	
Transportation (Per Diem)	Day	350	120.00	27.54	1156680.00	
Public Transportation	Outcome Based	3303	92.00	5.53	1680434.28	
Supported Employment - Job Finding and Job Support Total:						1522220.70
Job Finding	Quarter Hour	455	137.00	12.21	761110.35	
Job Support	Quarter Hour	455	137.00	12.21	761110.35	
Supported Employment	N/A	0	0.00	0.01	0.00	
Assistive Technology Total:						245905.85
Assistive Technology	Year	85	1.00	2893.01	245905.85	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Supports Coordination Total:						45976653.00
Supports Coordination	Quarter Hour	17646	150.00	17.37	45976653.00	
Homemaker/Chore Total:						693028.00
Homemaker/Chore	Hour	742	40.00	23.35	693028.00	
Prevocational Services Total:						43445395.15
Basic Staff Support	Quarter Hour	2395	3249.00	1.73	13461744.15	
Level 1	Quarter Hour	1402	3200.00	1.84	8254976.00	
Level 2	Quarter Hour	800	3100.00	1.92	4761600.00	
Level 3	Quarter Hour	622	3100.00	1.93	3721426.00	
Level 3 Enhanced	Quarter Hour	604	3100.00	2.04	3819696.00	
Level 4	Quarter Hour	572	3100.00	2.55	4521660.00	
Level 4 Enhanced	Quarter Hour	563	3100.00	2.81	4904293.00	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Residential Habilitation Total:						1082481907.20

CH 3800, Child Residential Services	Day	100	320.00	306.00	9792000.00	
CH 5310, Community Residential Rehabilitation Services	Day	100	320.00	306.00	9792000.00	
CH 6400, Community Homes	Day	9398	320.00	286.62	861969523.20	
CH 6500, Family Living	Day	1500	320.00	240.72	115545600.00	
Unlicensed Community Homes	Day	600	320.00	295.80	56793600.00	
Unlicensed Family Living	Day	360	320.00	248.17	28589184.00	
Residential Habilitation	N/A	0	0.00	0.01	0.00	
Home Finding Total:						147504.00
Home Finding	Quarter Hour	56	200.00	13.17	147504.00	
Transitional Work Services Total:						1877945.90
Basic Staff Support	Quarter Hour	346	600.00	4.08	847008.00	
Level 1	Quarter Hour	258	580.00	5.16	772142.40	
Level 2	Quarter Hour	95	370.00	5.41	190161.50	
Level 3	Quarter Hour	30	310.00	7.38	68634.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation Total:						81368542.00
Basic Staff Support	Quarter Hour	890	3200.00	3.26	9284480.00	
Level 1	Quarter Hour	826	3000.00	4.03	9986340.00	
Level 2	Quarter Hour	800	2950.00	6.58	15528800.00	
Level 3	Quarter Hour	683	2900.00	6.99	13845093.00	
Level 3 Enhanced	Quarter Hour	500	2900.00	7.80	11310000.00	
Level 4	Quarter Hour	400	2830.00	10.18	11523760.00	
Level 4 Enhanced	Quarter Hour	350	2614.00	10.81	9890069.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Therapy Services Total:						2095466.57
Physical Therapy	Quarter Hour	367	103.00	16.45	621826.45	
Occupational Therapy	Quarter Hour	323	10.00	17.43	56298.90	
Speech/Language Therapy	Quarter Hour	59	58.00	17.35	59371.70	
Visual/Mobility Therapy	Quarter Hour	29	489.00	15.92	225761.52	
Behavior Therapy	Quarter Hour	1838	32.00	19.25	1132208.00	

Licensed Day Habilitation Total:						96744341.80
Basic Staff Support (CH 2380)	Quarter Hour	1328	3200.00	2.50	10624000.00	
Level 1 (CH 2380)	Quarter Hour	1064	3700.00	2.86	11259248.00	
Level 2 (CH 2380)	Quarter Hour	1028	3700.00	3.06	11639016.00	
Level 3 (CH 2380)	Quarter Hour	1000	3100.00	3.47	10757000.00	
Level 3 Enhanced (CH 2380)	Quarter Hour	913	2520.00	4.08	9387100.80	
Level 4 (CH 2380)	Quarter Hour	500	2620.00	5.10	6681000.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	485	3460.00	5.41	9078521.00	
Older Adult Day	Quarter Hour	2029	3300.00	4.08	27318456.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:						6380886.52
Home Accessibility Adaptations	Year	1244	1.00	5129.33	6380886.52	
Behavioral Support Total:						350161.92
Behavioral Support	Quarter Hour	447	64.00	12.24	350161.92	
Vehicle Accessibility Adaptations Total:						1903320.00
Vehicle Accessibility Adaptations	Year	311	1.00	6120.00	1903320.00	
Education Support Services Total:						545913.94
Education Support Services	Year	169	1.00	3230.26	545913.94	
Supports Broker Services Total:						2109893.94
Supports Broker Services	Quarter Hour	3267	98.00	6.59	2109893.94	
GRAND TOTAL:					1406160017.32	
Total Estimated Unduplicated Participants:					17646	
Factor D (Divide total by number of participants):					79687.18	
Average Length of Stay on the Waiver:					342	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 (renewal only)

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8922100.56
Nursing	Quarter Hour	201	4028.00	11.02	8922100.56	
Respite Total:						10650487.82
15-Minute Respite - Basic Staff Support	Quarter Hour	320	1385.00	2.87	1271984.00	
15-Minute Respite - Level 1	Quarter Hour	313	1180.00	3.12	1152340.80	
15-Minute Respite - Level 2	Quarter Hour	300	800.00	3.22	772800.00	
15-Minute Respite - Level 2 Enhanced	Quarter Hour	300	1200.00	5.69	2048400.00	
15-Minute Respite - Level 3	Quarter Hour	200	995.00	8.42	1675580.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	170	958.00	8.42	1371281.20	
24-Hour Respite - Basic Staff Support	Day	255	11.00	239.29	671208.45	
24-Hour Respite - Level 1	Day	243	11.00	244.49	653521.77	
24-Hour Respite - Level 2	Day	126	10.00	254.90	321174.00	
24-Hour Respite - Level 2 Enhanced	Day	86	10.00	309.00	265740.00	
24-Hour Respite - Level 3	Day	64	9.00	369.34	212739.84	
24-Hour Respite - Level 3 Enhanced	Day	64	9.00	405.76	233717.76	
Temporary Respite	N/A	0	0.00	0.01	0.00	
Overnight Respite	N/A	0	0.00	0.01	0.00	
Companion Total:						1291680.00
Basic Staff Support	Quarter Hour	60	1100.00	2.60	171600.00	
Level 1	Quarter Hour	60	1100.00	3.64	240240.00	
Level 2	Quarter Hour	70	900.00	4.16	262080.00	
Level 3	Quarter Hour	110	900.00	6.24	617760.00	
Transportation Total:						18047901.36
Transportation (Mile)	Mile	339	833.00	0.56	158136.72	
Transportation (Trip)	Trip	2860	180.00	29.13	14996124.00	
Transportation (Per Diem)	Day	350	120.00	28.09	1179780.00	
Public Transportation	Outcome Based	3303	92.00	5.64	1713860.64	
Supported Employment - Job Finding and Job Support Total:						1552141.50
Job Finding	Quarter Hour	455	137.00	12.45	776070.75	
Job Support	Quarter Hour	455	137.00	12.45	776070.75	

Supported Employment	N/A	0	0.00	0.01	0.00	
Assistive Technology Total:						250823.95
Assistive Technology	Year	85	1.00	2950.87	250823.95	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Supports Coordination Total:						46903068.00
Supports Coordination	Quarter Hour	17646	150.00	17.72	46903068.00	
Homemaker/Chore Total:						706977.60
Homemaker/Chore	Hour	742	40.00	23.82	706977.60	
Prevocational Services Total:						44302893.80
Basic Staff Support	Quarter Hour	2395	3249.00	1.76	13695184.80	
Level 1	Quarter Hour	1402	3200.00	1.88	8434432.00	
Level 2	Quarter Hour	800	3100.00	1.96	4860800.00	
Level 3	Quarter Hour	622	3100.00	1.97	3798554.00	
Level 3 Enhanced	Quarter Hour	604	3100.00	2.08	3894592.00	
Level 4	Quarter Hour	572	3100.00	2.60	4610320.00	
Level 4 Enhanced	Quarter Hour	563	3100.00	2.87	5009011.00	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Residential Habilitation Total:						1104122592.00
CH 3800, Child Residential Services	Day	100	320.00	312.12	9987840.00	
CH 5310, Community Residential Rehabilitation Services	Day	100	320.00	312.12	9987840.00	
CH 6400, Community Homes	Day	9398	320.00	292.35	879201696.00	
CH 6500, Family Living	Day	1500	320.00	245.53	117854400.00	
Unlicensed Community Homes	Day	600	320.00	301.72	57930240.00	
Unlicensed Family Living	Day	360	320.00	253.13	29160576.00	
Residential Habilitation	N/A	0	0.00	0.01	0.00	
Home Finding Total:						150416.00
Home Finding	Quarter Hour	56	200.00	13.43	150416.00	
Transitional Work Services Total:						1914779.40
Basic Staff Support	Quarter Hour	346	600.00	4.16	863616.00	
Level 1	Quarter Hour	258	580.00	5.26	787106.40	

Level 2	Quarter Hour	95	370.00	5.52	194028.00	
Level 3	Quarter Hour	30	310.00	7.53	70029.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation Total:						83009918.00
Basic Staff Support	Quarter Hour	890	3200.00	3.33	9483840.00	
Level 1	Quarter Hour	826	3000.00	4.11	10184580.00	
Level 2	Quarter Hour	800	2950.00	6.71	15835600.00	
Level 3	Quarter Hour	683	2900.00	7.13	14122391.00	
Level 3 Enhanced	Quarter Hour	500	2900.00	7.96	11542000.00	
Level 4	Quarter Hour	400	2830.00	10.38	11750160.00	
Level 4 Enhanced	Quarter Hour	350	2614.00	11.03	10091347.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Therapy Services Total:						2137745.26
Physical Therapy	Quarter Hour	367	103.00	16.78	634300.78	
Occupational Therapy	Quarter Hour	323	10.00	17.78	57429.40	
Speech/Language Therapy	Quarter Hour	59	58.00	17.70	60569.40	
Visual/Mobility Therapy	Quarter Hour	29	489.00	16.24	230299.44	
Behavior Therapy	Quarter Hour	1838	32.00	19.64	1155146.24	
Licensed Day Habilitation Total:						98673553.60
Basic Staff Support (CH 2380)	Quarter Hour	1328	3200.00	2.55	10836480.00	
Level 1 (CH 2380)	Quarter Hour	1064	3700.00	2.92	11495456.00	
Level 2 (CH 2380)	Quarter Hour	1028	3700.00	3.12	11867232.00	
Level 3 (CH 2380)	Quarter Hour	1000	3100.00	3.54	10974000.00	
Level 3 Enhanced (CH 2380)	Quarter Hour	913	2520.00	4.16	9571161.60	
Level 4 (CH 2380)	Quarter Hour	500	2620.00	5.20	6812000.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	485	3460.00	5.52	9263112.00	
Older Adult Day	Quarter Hour	2029	3300.00	4.16	27854112.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:						6508508.48
Home Accessibility Adaptations	Year	1244	1.00	5231.92	6508508.48	

Behavioral Support Total:						357027.84
Behavioral Support	Quarter Hour	447	64.00	12.48	357027.84	
Vehicle Accessibility Adaptations Total:						1941386.40
Vehicle Accessibility Adaptations	Year	311	1.00	6242.40	1941386.40	
Education Support Services Total:						556833.03
Education Support Services	Year	169	1.00	3294.87	556833.03	
Supports Broker Services Total:						2151515.52
Supports Broker Services	Quarter Hour	3267	98.00	6.72	2151515.52	
GRAND TOTAL:						1434277350.12
Total Estimated Unduplicated Participants:						17646
Factor D (Divide total by number of participants):						81280.59
Average Length of Stay on the Waiver:						342