

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:**
Person/Family Directed Support Waiver
- C. **Waiver Number: PA.0354**
Original Base Waiver Number: PA.0354.9
- D. **Amendment Number: PA.0354.R02.04**
- 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 language to reflect new business practices for the Person/Family Directed Support Waiver which includes more details on the rate setting methodologies, clarification and updates to participant direction opportunities, revisions to the ODP Quality Management Strategy and performance measures for each assurance area and to update and clarify service definitions and provider qualification criteria. The work plan has been updated to reflect the status of the work plan activities.

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 checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C – Participant Services	
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	
<input checked="" type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

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:

General update to reflect current business practices as needed in each appendix. Incorporation of ODP's revised Quality Management Strategy, and quality performance measures. Incorporation of ODP policies related to the use of agencies designated as Organized Health Care Delivery Systems, add more details on the rate setting methodologies, clarification and updates to participant direction opportunities, and to update and clarify service definitions and provider qualification criteria. The work plan has been updated to reflect the status of the work plan activities.

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*):
Person/Family Directed Support Waiver
- C. **Type of Request: amendment**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

- 3 years
- 5 years

Original Base Waiver Number: PA.0354
Waiver Number: PA.0354.R02.04
Draft ID: PA.02.02.04

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 the ODP Bulletin on, 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)(1)(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 operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

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 P/FDS Waiver has been developed to emphasize deinstitutionalization and to prevent or minimize institutionalization. The P/FDS 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 participant-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 State Medicaid Agency, is responsible for the development and distribution of policies, rules, and regulations related to waiver operations. 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 P/FDS Waiver. The Agreement establishes the roles and responsibilities of AE's with respect to fiscal and program administration.

AE's may delegate and purchase administrative functions in accordance with the Operating Agreement. When the AE delegates or purchases administrative functions, the AE shall continue to retain ultimate responsibility for compliance with the AE Operating Agreement. In addition, the AE is responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental regulations, waiver requirements, written policies and procedures, state and federal laws, and the provisions of the Operating Agreement. Costs of purchased administrative functions 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 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 that ISP's include the services and supports necessary to meet the assessed needs of waiver participants. AE's are responsible to monitor 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.

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*):

- Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - 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 Improvement Strategy.** Appendix H contains the Quality Improvement 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 Improvement.** 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 Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
The major components of the amendment were distributed for 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:

Phone: **Ext:** **TTY**

Fax:

E-mail:

- 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:
State: **Pennsylvania**
Zip:
Phone:
Fax:
E-mail:

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Pennsylvania Office of Developmental Programs (ODP)

(Complete item A-2-a).

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

Specify the division/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-b*).

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Deputy Secretary of the Office of Developmental Programs reports directly to the Secretary of Public Welfare. The Secretary of Public Welfare is the head of the single state Medicaid agency. The Office of Developmental Programs functions as part of the Department of Public Welfare. The Secretary of Public Welfare, the State Medicaid Director and the Deputy Secretary of Developmental Programs meet regularly to discuss operations of the waivers and other long term living programs. Therefore, the State Medicaid Agency through Secretary of Public Welfare has ultimate authority over operations of the waiver.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. 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.

	 
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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 P/FDS Waiver, including the development of waiver-related policies, rules, and regulations. In addition to regulations, waiver 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 (AE) Operating Agreement and applicable regulations and policies:

1. Implementation of Department decisions and findings as per the AE Operating Agreement.
2. Monitoring of delegated or purchased administrative functions pursuant to a signed contract or agreement.
3. Maintaining, safeguarding, and providing access to waiver records as per the AE Operating Agreement.
4. Correction of issues resulting from Department monitoring and the AEs annual administrative review, as per the AE Operating Agreement.
5. Monitoring to ensure Prioritization of Urgency of Need for Services (PUNS) forms are completed to assign waiver applicants with a category of need for waiver services.
6. Ensuring that eligible applicants assessed as having an emergency needs, as defined in PUNS, receive preference in waiver enrollment over those assessed with a critical or planning need.
7. Authorization of all approved waiver funded services utilizing criteria established by ODP.
8. Qualification of waiver providers using the qualification criteria outlined in the current approved P/FDS Waiver, with the exception of supports coordination organizations. The AE is responsible to ensure providers they are qualifying hold a signed Provider Agreement for Participation in Pennsylvania's Consolidated and Person/Family Directed Support Waivers (ODP Provider Agreement) with ODP.
9. Monitoring of waiver providers, including Supports Coordination Organizations, utilizing the monitoring processes developed by ODP, as per the AE Operating Agreement.
10. Ensuring that information on participant direction is provided to waiver applicants and participants as per the AE Operating Agreement.
11. Evaluation and reevaluation of level of care as specified in the approved waiver.

12. Providing waiver applicants who are likely to be determined eligible for an ICF/MR level of care with service delivery preference between home and community based and institutional services.
13. Monitoring to ensure fair hearing and appeal rights are explained to waiver applicants and participants, and that Departmental fair hearing appeal information and notice and needed assistance is provided in filing fair hearing requests, as per the Operating Agreement and Departmental policies.
14. Conducting desk reviews of providers cost reports and review provider financial audits, as per the AE Operating Agreement.
15. Using the ODP quality structure AEs develop and implement a written quality management plan as per the AE Operating Agreement.
16. Participation in ODP required trainings as per the AE Operating Agreement.

AE's may delegate or purchase administrative functions, as per the AE Operating Agreement. When such functions are delegated or purchased, the AE is held accountable for the functions it delegates in compliance with the AE Operating Agreement. ODP retains the ultimate responsibility for the performance of AE's, and other contracted entities.

- 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 P/FDS 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 P/FDS 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 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 AEs and other contracted entities. ODP has oversight to the functions delegated to the AE through the Administrative Entity Oversight Monitoring process. A significant portion of the ODP Administrative Entity Oversight Monitoring process includes Supports Coordination activity to ensure compliance with the approved waiver. In addition, ODP requires AEs to conduct monitoring of waiver providers, including 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 P/FDS Waiver. This includes development of regulations and waiver-related policies 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 complaint reviews, incident management (IM), risk management (RM), service authorization reviews and the AE Oversight Monitoring process (AEOMP). ODP requires the AE conduct an Annual Administrative Review every year. ODP has developed a standardized AE Oversight Monitoring Tool that is also used by AEs in completing their Annual Administrative Review. The AE must establish a review period/cycle each year for their Annual Administrative Review. The AE must provide that review period/cycle to ODP in writing. The AE must submit a written report of the AE Annual Administrative Review per the AE Operating Agreement. The AEOMP which includes the AE Annual Administrative Review is ODP's structured process, used to assess and determine the degree in which the AE is following proscribed state and federal policies in a consistent manner across the Commonwealth. ODP provides any additional training and technical assistance to support the AE in the completion of the Annual Administrative Review.

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 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 and AE. ODP Regional Offices also conduct a management review of 24 hour incident reports (see Appendix G-1) to determine appropriate action to protect the individual; correct incident categorization; certified investigation occurred when needed; proper safeguards

are in place; and corrective action has or will take place.

Each ODP Regional Office RM Workgroup meets at least monthly to review and analyze regional RM data, provide feedback to AEs and providers around RM/IM, develop regional improvement plans for RM/IM priorities, coordinate regional RM/IM trainings, lead regional RM initiatives, coordinate regional RM forums, and assess and track outcomes of target objectives. Regional RM Workgroups 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, and certified investigations.

Regional RM Forums are led by the ODP Regional Risk Manager and consist of AE RM staff and include some provider participation. The forums are conducted on at least a quarterly basis. These forums are used to foster collaboration with ODP regarding the identification and implementation of regional RM priorities. The forum members: review and analyze RM data, identify potential improvement strategies for implementation at the AE level, recommend regional and county RM/IM improvement priorities, monitor local incident levels identified for improvement, assure alignment of efforts to manage risk within AEs, assess and track outcomes of target objectives, and modify target objectives and established priorities as needed. All of the information shared during the forums is then reported at regional RM meetings and shared during the Statewide RM meeting.

Additional information is obtained through Independent Monitoring for Quality (IM4Q), a statewide method that PA has adopted to independently review quality of life issues 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 providers.

ODP also completes AEOMP, which involves review of AE performance, consisting of: reports from ODPs Division of Program Analysis; information regarding Quality, Employment, Lifesharing, IM4Q, Financial Management, Licensing and RM; sample of ISPs, PUNS data, monitoring and service notes; and onsite visits to the AE and people receiving services.

The AEOMP uses an ODP Regional AE Oversight Team for review and oversight of each AE. ODPs Division of Program Analysis generates a seven percent sample of individuals (with a minimum of 5 and a maximum of 50 records) for review of specific indicators. A subset of individuals is targeted for face-to-face interviews. AEOMP is implemented on a staggered schedule, with a formal onsite review of each AE at least every 2 years. AEOMP the following general areas:

- Quality of Life – ISP review, supports coordination monitoring, PUNS, HCSIS data integrity, quality management, incident management, and IM4Q
- ODP Initiatives – employment and lifesharing
- AE Capacity – to meet ODP requirements
- Rights – due process, choice, and service reviews
- Eligibility – service delivery preference and level of care determinations and redeterminations
- Financial Management – service authorizations, claims resolution, cost reporting process, financial reporting
- Provider Monitoring – provider qualification standards and other requirements
- Other AE Functions – annual administrative review, meeting needs of participants, individual personal funds, AEOMP compliance, waiver capacity management, and vendor/fiscal FMS

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. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of cases in which final orders by the Department's Bureau of Hearing and Appeals are implemented within 30 calendar days of the order. (Delegated function: Implementation of Department decisions and findings as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation	Frequency of data collection/generation	Sampling Approach (check each that applies):
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<i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which service review findings are implemented within 30 calendar days of receipt of the findings, unless otherwise directed. (Delegated function: Implementation of Department decisions and findings as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of AEs that maintain and safeguard records as per the AE Operating Agreement. (Delegated function: Maintaining, safeguarding, and providing access to waiver records as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<input checked="" type="checkbox"/> Other Specify: Every 6 months
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Performance Measure:
 Number and percent of AEs that perform an annual administrative review as per the AE Operating Agreement. (Delegated function: Correction of issues resulting from Department monitoring and the AEs annual administrative review, as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:
HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number and percent of AE corrective action plans implemented as written. (Delegated function: Correction of issues resulting from Department monitoring and the AEs annual administrative review, as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which a PUNS (Prioritization of Urgency of Need for Services) has been completed. (Delegated function: Ensuring PUNS forms are completed to assign waiver applicants with a category of need for waiver services.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which the PUNS has been updated at least every 365 days. (Delegated function: Ensuring PUNS forms are completed to assign waiver applicants with a category of need for waiver services.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which the PUNS is updated no later than 30 calendar days after the recognition or notification of a change in need. (Delegated function: Ensuring PUNS forms are completed to assign waiver applicants with a category of need for waiver services.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants

	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which all services and supports are incorporated in ISPs, including services paid through ODP, informal services and other formal services paid for by other funding resources, i.e. Education, OVR, EPSDT, etc. (Delegated function: Authorization of all approved waiver funded services utilizing criteria established by ODP.) (Also see Performance Measures in Appendix D.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants	
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of providers AEs qualify utilizing ODP standards as outlined in the approved waiver. (Delegated function: Qualification of providers using criteria outlined in the waiver, with the exception of Supports Coordination Organizations. The AE is responsible to ensure providers they qualify hold a signed Waiver Provider Agreement with ODP.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of AEs that conduct SCO/provider monitoring utilizing ODP standards. (Delegated function: Monitoring of waiver providers, including SCOs, utilizing the monitoring processes developed by ODP as per the AE Operating Agreement.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which the AE ensures that each individual that receives waiver services is eligible for an ICF/MR LOC. (Delegated function: Evaluation and reevaluation of LOC as specified in the approved waiver.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>

<i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which a LOC evaluation was completed that includes a: Medical Evaluation (with ICF/MR LOC and MR diagnosis), psychological evaluation, signed and dated standardized adaptive assessment, signed and dated certification of need for ICF/MR LOC (form DP-250). (Delegated function: Evaluation and reevaluation of LOC as specified in the approved waiver.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which the Annual Recertification of Need for ICF/MR LOC (form DP-251) is completed. (Delegated function: Evaluation and reevaluation of LOC as specified in the approved waiver.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<input checked="" type="checkbox"/> Other Specify: Every 6 months
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Performance Measure:
 Number and percent of cases in which there is a signed and dated Service Delivery Preference form (DP-457). (Delegated function: Providing waiver applicants who are likely to be determined eligible for ICF/MR LOC with service delivery preference between home and community-based and institutional services.)

Data Source (Select one):
Other

If 'Other' is selected, specify:
HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Specify: <input style="width: 90%; height: 20px;" type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of cases in which individuals/representatives receive notice of due process rights and instructions for filing an appeal: at registration; upon enrollment; at each ISP meeting and upon notification of a denial, reduction or termination of waiver services. (Delegated function: Ensuring appeal rights are explained and that Departmental appeal information and notice are provided.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 80%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 80%; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input style="width: 80%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percentage of AEs that ensure the provision of needed assistance in completing and filing an appeal. (Delegated function: Ensuring needed assistance is provided in filing fair hearing requests, as per the Operating Agreement and Departmental policies.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of AEs that conduct desk reviews of provider cost reports per ODP instructions. (Delegated function: Conducting desk reviews and financial audits as per the AE Operating Agreement.)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of AEs that submit quarterly administrative waiver expenditure reports to ODP within 14 working days of the end of the quarter. (Delegated function: Conducting desk reviews and financial audits as per the AE Operating Agreement.)

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of AEs that submit a Quality Management Plan to ODP as per the AE Operating Agreement. (Delegated function: Developing and implementing a written quality management plan as per the AE Operating Agreement.)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:	
	<input type="checkbox"/> Other Specify:		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of AEs that implement their Quality Management Plans.
(Delegated function: Developing and implementing a written quality management plan as per the AE Operating Agreement.)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: April and September	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: May and October

Performance Measure:

Number and percent of AEs that participate, as required, in ODP Academy sessions. (Delegated function: Participation in ODP required trainings as per the AE Operating Agreement.)

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ODP instituted the AE Oversight Monitoring process (AEOMP) to ensure that AEs perform operational and administrative functions related to the approved waivers. AEs authorize all services and supports funded under the waiver pursuant to an AE Operating Agreement with ODP. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to fiscal and program administration.

The AEOMP involves continuous data collection, analysis, and review of specific, standard indicators

reflecting compliance with waiver assurances and other State requirements. ODP's Division of Program Analysis generates a statistically significant random sample of individuals from the Waiver—7%, for the review of ISPs, Individual Monitoring, provision of choice, eligibility/level of care, record retention, and data integrity. A subset of the individuals in the sample is identified for face-to-face interviews. The AEOMP is implemented on a staggered schedule, with a formal onsite review of each AE at least every 2 years.

The AEOMP was developed to assure an ongoing process of discovery, remediation and improvement. As areas of non-compliance are identified in an AE (discovery), a Final Report that identifies areas of non-compliance as well as recommendations (remediation) is provided to the AE. In response, the AE is required to complete a Corrective Action Plan to address the findings in the AE Oversight Monitoring Final Report through remediation and improvement. The Corrective Action Plan is subject to review, approval, and validation by ODP.

Individual issues related to AE performance are identified by ODP Regional Office (RO) staff through the AEOMP, review of AE corrective action plans and the validation of those plans, service review of appeal requests and BHA determinations, and ODP investigations. 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: Notification of the noncompliance to the AE; technical assistance to the AE by ODP; a required or directed plan of correction; freeze of AE enrollments pending an acceptable plan of correction; intensified monitoring of the AE by ODP; and/or termination or non-renewal of the Agreement. If ODP freezes enrollment by an AE, another AE will be used for emergency enrollments.

During the AEOMP, individual problems may surface through the review of individual records. If an individual issue arises, ODP RO staff works with the AE to develop a remediation plan. Through the validation process outlined in the AE Operating Agreement, the RO follows up to ensure the issue has been corrected.

In addition, ODP uses the following strategies to remediate individual problems as they occur:

- ODP has developed a standardized AE Oversight Monitoring Tool, used by AEs in completing their Annual Administrative Reviews. If an AE fails to provide ODP written communication of the AE annual review period/cycle for completion of the AE Administrative Review and/or fails to complete the Review and follow up in the cycle identified, ODP contacts the AE and requires a corrective action plan to assure completion of the requirement. ODP provides any additional training and technical assistance to support the AE in the completion of the Annual Administrative Review.
- On a monthly basis, a PUNS Not Updated within 365 Days Report is made available to AEs. AEs use this report to identify any individual cases in which a PUNS form has not been updated within 365 days for individuals with a PUNS on record and to follow up with the involved SC to update the PUNS form. On a quarterly basis, the AE analyzes data from monthly reports to determine if there is a systemic issue at an SC or SCO level that results in a failure of the PUNS to be updated within 365 days. If a systemic issue is identified, the AE is responsible to work with the SCO to develop a plan of correction. The AE then monitors the monthly reports to ensure the plan of correction has been implemented and has been effective.
- When a request for a service requiring advance authorization by ODP is received, ODP will validate that the service has not already been authorized by the AE. If the AE inappropriately authorized the service in advance of ODP's approval or disapproval, ODP will inform the AE of the inappropriate action and provide technical assistance to the AE to ensure the proper procedure is followed. Additional action will be taken by ODP if there is a reoccurrence.
- ODP validates that providers appearing in ISPs have a signed Provider Agreement with ODP. In addition, ODP verifies the presence of a signed Provider Agreement prior to processing a PROMISE enrollment request, and validates this through the provider qualification process. ODP contacts any provider not having a signed Provider Agreement for signature or disqualification. Claims submitted by providers who render services without a signed Provider Agreement are denied. AEs that have authorized providers who do not have a signed Provider Agreement will be contacted and technical assistance will be provided to them to avoid reoccurrence.
- Using the ODP quality structure AEs develop and implement an annual quality management plan per the AE Operating Agreement. Technical assistance is provided to AEs to assist them as they develop and implement Annual QM Plans. If an AE does not submit and/or implement an Annual QM Plan, directed technical assistance is provided to assist the AE to develop, submit, and implement a Plan.
- ODP assesses whether staff designated to attend ODP-required trainings in the AE Operating Agreement fulfills this requirement. AEs that fail to meet requirements for attendance are notified in writing of the failure to comply. ODP follows up with the AEs to ensure attendance at subsequent required training sessions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ODP is working with National Quality Enterprise (NQE) on its Quality Improvement Strategy and any changes that may be needed by July 1, 2012.

ODP is developing a process to ensure that AEs delegate or purchase only those administrative functions that are permitted to be delegated or purchased in accordance with the AE Operating Agreement and that AEs monitor any delegated or purchased administrative function. ODP plans to use the following performance measures to evaluate effectiveness: A. Number of AEs that delegate or purchase administrative functions. B. Number and percent of delegated or purchased administrative functions that each AE monitors. The target date for implementation of this process is June 1, 2010.

On a quarterly basis, beginning January 2010, Waiver Capacity Managers will review those individuals who have newly entered the queue for entry into the waiver to ensure they have an emergency need as defined in PUNS. In any case where an individual does not have an emergency need, the Waiver Capacity Manager will review the circumstances with the AE to ensure that ODP's criteria for enrollment were applied.

Services requiring prior authorization by ODP should not be authorized by AEs until ODP's authorization is obtained. ODP employs a Request for Exception to Service Limit Form to request an exception to a service limit. Beginning July 2010, ODP will review services requiring ODP approval to ensure authorizations are made appropriately and claims are processed appropriately. The following performance measure will be used to evaluate this delegated function: Number and percent of cases in which prior authorization is obtained from ODP when required.

Currently, AE monitoring of waiver providers is reviewed through the AEOMP. Pending the development of a standardized monitoring process by ODP, AEs are expected to follow existing provider monitoring processes to satisfy this requirement. ODP will require AEs to use the standardized provider monitoring process that is under development by July 2011, beginning with SCOs and then implementing for other waiver service providers.

ODP is issuing an ISP policy that will include a standard documentation requirement that an ISP Participant's Signature Page is completed and on file documenting that FMS options were discussed. The SC will begin to use the form effective January 2011; at that point, ODP intends to use the form during AEOMP to ensure the assurance was met.

ODP currently uses AEOMP to evaluate whether service delivery preference was offered. By January 1, 2011, ODP will develop and use a report using HCSIS data to determine whether 100% of waiver applicants who are likely to be determined eligible for an ICF/MR level of care are provided service delivery preference.

A change was made in HCSIS effective July 25, 2009, and with this change the AE can no longer enroll an individual into a waiver unless capacity exists. ODP has trained AEs that all AEs must enter an individual into the Intent to Enroll status to first ensure that sufficient waiver capacity exists to support the individual. If the information in HCSIS is not showing existing unfilled capacity, this cannot be accomplished. The Waiver Capacity Managers will be monitoring the process.

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 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 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 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 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:

Individuals residing in licensed Community Homes for Individuals with Mental Retardation (55 PA Code Chapter 6400), licensed Family Living Homes (55 PA Code Chapter 6500), licensed Child Residential Facilities (55 PA Code Chapter 3800), and licensed Community Residential Rehabilitation Services (55 PA Code Chapter 5310) are excluded from enrollment in the P/FDS Waiver.

Individuals residing in licensed Personal Care Homes (55 PA Code Chapter 2600) with eleven (11) or more residents with a move-in date for the Personal Care Home of July 1, 2008 or after are excluded from enrollment in the P/FDS Waiver. The move-in date applies to the Personal Care Home where the person is residing and may not be transferred to a new home.

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*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- 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	10739
Year 2	12045
Year 3	12045
Year 4	12045
Year 5	12045

- 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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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).**

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 based upon historical usage. Each AE receives an annual commitment letter that outlines their assigned capacity. If the Legislature appropriates additional funding, additional waiver capacity is committed based on information captured through the standardized Prioritization of Urgency of Need for Services (PUNS) form, which is entered in HCSIS.

A person is assigned a category of need through PUNS, based on a series of standard criteria. 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. AEs are responsible to ensure PUNS information is current.

If unused capacity exists with an AE, the capacity may be held and authorized at the state level or the state may commit the unused capacity to another AE. Participants may receive services anywhere in the Commonwealth they choose. Additionally, ODP may commit additional capacity to an AE based on unanticipated emergencies.

ODP also manages capacity for certain licensed residential settings (i.e. settings licensed under 55 Pa. Code Chapter 6400, Community Homes). Approved program capacity is established by the Department for each residential site based on the maximum number of Participants who, on any given day throughout the fiscal year, are authorized to receive residential habilitation at that site. The approved program capacity may include individuals residing at the home who are receiving residential services through base funding or other funding sources, including individuals who are paying privately.

Approved program capacity for specific service locations is determined by the Regional Waiver Capacity managers for homes licensed under 55 PA Code Chapter 6400. The baseline determination was developed using the number of individuals the providers stated were being supported in the home for the FY 2009-2010 cost report. That number was verified by the actual authorizations for service for individuals at the specific service location, and consultation with the provider to determine the total number of individuals who were being served

either through P/FDS Waiver funding or another funding stream. Requests to revise the approved program capacity will be approved or denied by the regional Waiver capacity Manager on a case by case basis.

- 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 enrollment 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.

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.

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

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

- 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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 in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- 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 standard included under the State Plan**

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:

- Other**

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:

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:

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:

- Other

Specify:

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)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- 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 and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- 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:

Supports Coordination services may not be considered when determining the frequency of services below.

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
- Companion
- Supported Employment
- Transitional Work Services
- Transportation

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 unlicensed 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 bed reservation 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 an ISP monitoring contact by Supports Coordinators at least once every calendar month and a face-to-face monitoring contact at least once every three calendar months, 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
- 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.

- 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.

- 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 the 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.

- 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 §92.42. 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 current AE Operating Agreement.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of individuals enrolled in the waiver within the prior 12 months who have a level of care completed prior to entry in the waiver.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
---	--	--

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number of days it took to complete the level of care evaluation: a. Number occurring within 45 days, b. Number requiring an extension of the 45-day limit, c. Reasons for extensions are documented in HCSIS.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number of applicants meeting ICF/MR level of care.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<input checked="" type="checkbox"/> Other Specify: Every 6 months
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Performance Measure:
Number of applicants denied.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
 Number and percent of individuals determined as not meeting ICF/MR level of care that are notified of their due process/appeal rights.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of cases in which the Annual Recertification of Need for ICF/MR LOC (DP 251) form is completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

Entities		
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number and percent of cases in which the annual level of care recertification date is entered into HCSIS.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of cases in which the level of care evaluation was completed that includes a: Medical Evaluation (with ICF/MR level of care and MR diagnosis), Psychological Evaluation, Signed and dated Standardized Adaptive Assessment, and Signed and dated Certification of Need for ICF/MR LOC (DP 250).

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Specify: <input style="width: 95%; height: 20px;" type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
 Number and percent of cases in which the level of care evaluation was completed by the correct professionals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 60px; height: 20px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 60px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input style="width: 60px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

ODP monitors level of care evaluations through the AE Oversight process. AE Oversight is a statewide process to monitor the performance of AEs 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 process requires an AE corrective action plan for issues of noncompliance. Individual issues related to Level of Care determinations and redeterminations are identified by ODP Regional Office (RO) staff through the AE Oversight Monitoring process (AEOM), review of AE corrective action plans and the validation of those plans, review of formal appeals and BHA determinations, and ODP investigations.

During the AEOM process, individual problems may surface through the review of individual records. If an individual issue arises, ODP Regional Office staff works with the AE to develop a remediation plan. Through the validation process, the Regional Office follows up to ensure that the issue has been addressed. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure they fully understand the process and apply it correctly.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ODP is working with National Quality Enterprise (NQE) on its Quality Improvement Strategy and any changes that may be needed by July 1, 2012.

In order to assist in tracking requirements related to initial level of care determination and level of care redetermination, ODP has created management and operational reports in HCSIS, including Individuals in Waiver Enrollment Queue Report and LOC Exception Summary Report, and plans to institute a process to use the reports to ensure compliance and address any areas of noncompliance by January 1, 2011.

ODP, with our Medical Director, is developing guidance and a technical assistance process to assist all AEs in applying level of care criteria by January 2011. Specific AEs identified through the AEOMP as applying level of care criteria incorrectly will be required to participate in targeted technical assistance.

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 delivery 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 delivery 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 §92.42, 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 or any ODP approved revisions.

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	Respite
Statutory Service	Supported Employment - Job Finding and Job Support
Statutory Service	Supports Coordination
Statutory Service	Unlicensed Residential Habilitation
Extended State Plan Service	Nursing Services
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 (16) 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 Educator
Agency	Education 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 Educator

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):

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:

Education 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. 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:

Statutory Service

Service:

Habilitation

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 assist individuals in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. 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. When services are provided by agency-based providers, this service also includes transportation services necessary to enable the individual to participate in the home and community habilitation service, in accordance with the individual's ISP. Through the provision of this service individuals learn, maintain, or improve skills through their participation in a variety of everyday life activities. 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. This service may not be provided in licensed settings, and is not a residential service; for residential services, see Residential Habilitation. Camp day or overnight may only be provided under respite.

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.

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 and qualifications.
2. Support that enables the individual to access and use community resources such as instruction in using transportation, translator and communication assistance related to a habilitative outcome, 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 is related to a habilitative outcome to enable 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 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.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may also be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of states contiguous to Pennsylvania.

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

This service may not overlap with or duplicate Companion Services. 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. 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.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, 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
Individual	Individual
Agency	Agency - Unlicensed Habilitation

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 or contiguous state statute.
- 9. 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:

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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the habilitation service
- 3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute.

Staff working for or contracted with 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
- 7. 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 member(s) or friend(s) 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 and 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.

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

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 and financially provide for the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents them from performing and 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 and financially provide for the homemaker/chore functions. A person is considered permanently unable when the condition or situation that prevents them from performing and 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 and 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
Agency	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

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 or contiguous state 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:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute.

Staff working for or contracting with 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. The service also includes transportation that is an integral component of the service, for example, transportation to a community activity. The Licensed Day provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provider in the individual's ISP. In this case, the transportation service must be billed as a discrete service.

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 Pennsylvania and 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, 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 - Licensed Day Habilitation Services

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 - Licensed Day Habilitation Services

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. Pennsylvania based providers must be licensed under 55 PA Code Chapter 2380 and/or 6 PA Code Chapter 11, or comparable license for providers based in states contiguous to Pennsylvania
2. Commercial General Liability Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the day habilitation service
4. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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):

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.

The service also includes transportation that is an integral component of the service, for example, transportation to a work activity. The Licensed Prevocational provider is not, however, responsible for transportation to and

from an individual's home, unless the provider is designated as the transportation provided in the individual's ISP. In this case, the transportation service must be billed as a discrete 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 1:15.
- 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 Pennsylvania and states contiguous to Pennsylvania.

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

Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the waivers.

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.

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, 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 - Vocational Facility

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 - Vocational Facility

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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the prevocational service
4. Workers' Compensation Insurance, when required by Pennsylvania statute

Staff working for or contracting with 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. Agreement 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 have a Degreed (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:

Service:

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 and 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. 15-minute respite is provided for periods of 16 hours or less, and is billed using a 15-minute unit.

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 owned, leased/rented, or operated (i.e. licensed and unlicensed Family Living homes)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.
4. 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 (55 Pa. Code Chapter 6400) or family living (55 Pa. Code Chapter 6500) home located in Pennsylvania within the home's approved program capacity. ODP may approve the provision of respite services above a home's approved program capacity on a case-by-case basis.
- Licensed Child Residential Service Home (55 Pa. Code Chapter 3800)
- Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa. Code Chapter 5310)
- 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 at a staff-to-individual ratio of 1:1 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.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of states contiguous to Pennsylvania.

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.

This service is not available for participants residing in agency-owned, rented/leased, or operated homes unless approved by ODP for an emergency.

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 licensed 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 contiguous to Pennsylvania.

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. 55 PA Code Chapter 3800, 6400, or 6500, when applicable or comparable license for providers based in states contiguous to Pennsylvania
2. Commercial General Liability Insurance
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the respite service
4. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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. Documentation that the individual 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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the respite service
7. Workers' Compensation Insurance, when required by Pennsylvania statute
8. 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: 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 by qualified providers based in Pennsylvania and 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.

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 or contiguous state 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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the employment service
3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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 by qualified providers based in Pennsylvania. During temporary travel, the service may be provided in Pennsylvania or other locations as per the ODP travel policy.

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	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, State-funded Case Management (direct services and administrative functions), the administration of Family Driven Support Service funds, and transportation for Supports Coordination Organizations that are county-based and share a FEIN with the county transportation service;
 - 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. Commercial General Liability Insurance

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

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

13. Has a process for utilizing the Home and Community Services Information System (HCSIS) to document and perform Supports Coordination activities.

14. Agrees to enter and update provider-related information in HCSIS and PROMISE for the Supports Coordination Organization.

15. Agrees to comply with rate setting and billing requirements for Supports Coordination services, which includes utilizing a process for reconciliation of claims and rebilling.

16. 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.

17. Has a signed standard Waiver Provider Contract with the applicable Administrative Entity(ies) until June 30, 2009 as per the current AE Operating Agreement.

18. Complies with HIPAA.

19. Cooperates with provider monitoring conducted by the applicable Administrative Entity(ies) or ODP or its agents.

20. 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.

21. Has a process to review the utilization of Supports Coordination services.

22. Has a Quality Management strategy consistent with the approved waiver.

23. Complies with the ODP Incident Management policy.

24. Complies with all applicable ODP policy bulletins.

25. 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.

26. Cooperates with Health Care Quality Units, independent monitoring teams, and other external monitoring conducted by ODP business agents.

27. 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.ssc.state.pa.us.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

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):

Unlicensed 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 to individuals who live in unlicensed residential provider-owned, rented/leased, or operated (i.e. unlicensed Family Living homes) residential settings. Services are provided up to 24 hours per day to protect the health and welfare of individuals who reside at the unlicensed residential setting by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. 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 also includes transportation services that are necessary to enable the individual to access services and resources outlined in the ISP, including transportation to and from day or employment services. The Unlicensed Residential provider is not responsible for transportation to community activities for which another provider is responsible. The Unlicensed Residential provider is not responsible for transportation when the individual is at a Day Habilitation, Prevocational, or Transitional Work service.

The unlicensed residential habilitation setting may only be located in Pennsylvania. All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings.

During temporary travel, the service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Unlicensed Residential Habilitation: Unlicensed Residential Habilitation may be provided to individuals who live in unlicensed residential provider-owned, rented, leased or operated 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.

Unlicensed Residential Enhanced Staffing may be utilized in Waiver-funded unlicensed residential settings. The enhanced staffing is treated as add-ons to the unlicensed residential service based on the assessed need of the individual. The continued need for Residential Enhanced Staff should be reviewed at least annually as part of the ISP process:

- The provision of the residential habilitation by licensed nurses for individuals living in unlicensed residential settings.

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 unlicensed residential service location 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 Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Unlicensed Residential Habilitation

Provider Category:

Provider Type:

Unlicensed Residential Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

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

Staff working for or contracting with 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: 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 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):

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."

During temporary travel, the service may be provided in Pennsylvania or other locations as per the ODP travel policy.

The service may also be provided on an ongoing basis by qualified providers based in Pennsylvania and 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, Medicare 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 Services

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

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

3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

4. Documentation that the nurse 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 Services

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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Nurses working for or contracting with agencies must meet the following standards:

1. Licensing standards outlined 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 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:

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.
- Occupational therapy by a registered occupational therapist based on a prescription for a specific therapy program by a physician.
- 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.

During temporary travel, the service may be provided in Pennsylvania or other locations as per the ODP travel policy.

The service may also be provided on an ongoing basis by qualified providers based in Pennsylvania and 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, Medicare 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	Occupational Therapy
Individual	Speech Language Therapist
Individual	Behavior Therapist
Individual	Visual/Mobility Therapist
Agency	Visual/Mobility Therapy
Individual	Occupational Therapist
Individual	Physical Therapist
Agency	Behavior Therapy
Agency	Speech Language Therapy
Agency	Physical Therapy

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

Provider Qualifications

License (specify):

Occupational Therapist

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Therapists working for or contracting with 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 therapist 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:

Speech Language Therapist

Provider Qualifications

License (specify):

State licensed speech-language pathologist

Certificate (specify):

ASHA certified

Other Standard (specify):

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

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 outlined 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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute
5. Documentation that the therapist 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:

Visual/Mobility Therapist

Provider Qualifications

License (specify):

Certificate (specify):

Trained visual or mobility specialist/instructor

Other Standard (specify):

1. Certification requirements outlined 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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute
5. Documentation that the specialist/instructor 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

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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Therapists working for or contracting with 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 specialist/instructor 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:

Occupational Therapist

Provider Qualifications

License (specify):

Occupational Therapist

Certificate (specify):

Other Standard (specify):

1. Licensing requirements outlined 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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute
5. Documentation that the therapist 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:

Physical Therapist

Provider Qualifications

License (specify):

Physical Therapist

Certificate (*specify*):

Other Standard (*specify*):

1. Licensing requirements outlined 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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute
5. Documentation that the therapist 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:

Provider Type:

Behavior Therapy

Provider Qualifications

License (*specify*):

Psychologist

Psychiatrist

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Therapists working for or contracting with 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 therapist 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

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. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Therapists working for or contracting with 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 therapist 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

Provider Qualifications

License (specify):

Physical Therapist

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Commercial General Liability Insurance
2. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Therapists working for or contracting with 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 therapist 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: 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 units and associated 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 services and associated funds;
- 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 or an Independent Monitoring Program).

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and 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 or contiguous state 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 or contiguous state statute
3. Commercial General Liability Insurance
4. 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 or contracting with 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 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:

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:

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 Pennsylvania and 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, Medicare 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

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 by an individual with a Masters Degree in Human Services (or a closely related field) or an individual under the supervision of a professional who is licensed or has a Masters 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.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and 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
Agency	Behavior Support Agency
Individual	Behavior Support Specialist

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 or contiguous state statute
3. Commercial General Liability Insurance

Behavior Support Specialist 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 Behavior Support Specialist 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. Have a Masters Degree in Human Services (or a closely related field) or work under the supervision of a professional who is licensed or has a Masters 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:

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 Behavior Support Specialist 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 or contiguous state 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. Have a Masters Degree in Human Services (or a closely related field) or work under the supervision of a professional who is licensed or has a Masters 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:

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 individuals 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 direct service. When services are provided by agency-based providers, this service also includes transportation services necessary to enable the individual to participate in the Companion service, in accordance with the 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 1:6.
- 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.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of 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. This service may not be provided at the same time as any other direct waiver service.

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 or contiguous state

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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the companion service
3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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 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

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 and family living homes that are privately owned, rented, or leased by the host family) 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, rented, leased, or operated 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 Pennsylvania and 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 Pennsylvania and/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. Compliance with the Pennsylvania Home Improvement Consumer Protection Act

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 Pennsylvania and/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. Compliance with the Pennsylvania Home Improvement Consumer Protection Act

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 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 Pennsylvania and 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 Home Finder

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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the home finding service
3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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 Home Finder

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 home finder 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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the home finding service
7. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute
8. 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 diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and 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.

This service is not available to individuals who reside in licensed or unlicensed residential habilitation homes.

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, Medicare 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. The goal for this service is employment. Individuals receiving this service must have an employment outcome included in their ISP.

The service also includes transportation that is an integral component of the service, for example, transportation to a work site. The Transitional Work provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provided in the individual's ISP. In this case, the transportation service must be billed as a discrete 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 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.

This service may be provided on an ongoing basis by qualified providers based in Pennsylvania and 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, 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. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the transitional work service
3. Workers' Compensation Insurance, when required by Pennsylvania statute or contiguous state statute

Staff working for or contracting with 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:

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):

Direct services to provide transportation to enable individuals to access services and activities specified in their approved ISP. This includes transportation that is provided by Adult Training Facilities, Prevocational Service and Transitional Work Service providers who transport individuals to and from their homes and provider sites. It is not transportation that is an integral part of the provision of activities within Habilitation Service settings nor is it transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the habilitation service.

Transportation services consist of:

1. **Transportation (Mile).** This transportation service is provided by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the qualified licensed driver who transports the individual to and from services and resources specified in the individual's ISP. The unit of service is one mile. Mileage will be paid round trip. The rate for this service is the current state rate for mileage reimbursement. When transportation is provided to more than one individual at a time, the total number of units of service that are to be provided are equitably divided among the individuals for whom transportation is provided.
2. **Public Transportation.** Public transportation services are provided to or purchased for individuals to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. Public transportation tokens and transit passes may be purchased by the AE, AE contracted payment agents, Financial Management Service Organizations, or providers of service. Tokens/passes that are purchased for an individual may be provided to the individual on a daily, weekly or monthly basis.
3. **Transportation – Per Diem.** This is transportation provided to an individual by provider agencies for non-emergency purposes. The service is designed to provide individuals with access to services and resources specified in their ISP.
4. **Transportation – Trip.** Transportation provided to individuals (excluding transportation included in the rate for habilitation services) for which costs are determined on a per trip basis. A trip is either transportation to a service from an individual's home or from the service to the individual's home. Taking an individual to a service and returning the individual to his/her home is considered two trips or two units of service.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel

policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of 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	Agency
Individual	Relative/Legal Guardian
Individual	Individual Non-Relative/Non-Legal Guardian

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Provider Type:

Agency

Provider Qualifications

License (specify):

Valid Pennsylvania or contiguous state driver's license

Certificate (specify):

-Current State motor vehicle registration

-PUC Certification, when required by Pennsylvania law or comparable certification for contiguous state

Other Standard (specify):

Agencies must meet the following standards:

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

Drivers working for or contracted with 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: 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 or contiguous state driver's license

Certificate (specify):

Current State motor vehicle registration

PUC Certification, when required by Pennsylvania law or comparable certification for contiguous state

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:

Individual 

Provider Type:

Individual Non-Relative/Non-Legal Guardian

Provider Qualifications

License (specify):

Valid Pennsylvania or contiguous state driver's license

Certificate (specify):

-Current State motor vehicle registration

-PUC Certification, when required by Pennsylvania law or comparable certification for contiguous state

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 or contiguous state 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: 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 that is used as the primary means of transportation to meet the individual's needs. The modifications must be necessary due to the individual's disability. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives, or a non-relative who provides primary support to the individual and is not a paid provider agency of services. This service may also be used to adapt a privately owned vehicle of a family living host family when the vehicle is not owned by an unlicensed family living provider agency.

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 on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of 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. Provision of Case Management Services to Waiver Participants. 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 waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- 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.*

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 requires that criminal background checks are requested from the Pennsylvania State Police prior to the applicant's date of hire. If the applicant has not been a resident of the Commonwealth for the two years immediately preceding the date of application, a report of Federal criminal history record must be requested from the Federal Bureau of Investigation (FBI) in addition to a criminal history record from the Pennsylvania State Police.

ODP requires child abuse clearances and FBI checks on all employees that come in contact with waiver participants who are under the age of 18. Specific requirements for these clearances are included in 23 Pa. C.S. Chapter 63.

Applicants may be hired on a provisional basis prior to the receipt of clearances if the applicant signs an affidavit indicating they have not been found guilty of any offenses listed in OAPSA or 23 Pa. C.S. Chapter 63.

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.

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
Personal Care Home
55 PA Code Chapters 6400 (Community Homes), 3800 (Child Residential Facilities), 5310 (Community Rehabilitative Residential Services)

- 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:

Personal Care Home

Waiver Service(s) Provided in Facility:

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

Licensed Day Habilitation	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>

Facility Capacity Limit:

10 people if the individual's move-in date for the Personal Care Home is July 1, 2008 or after.

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:

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

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Education Support Services	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Home Accessibility Adaptations	

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

	<input type="button" value="▲"/> <input type="button" value="▼"/>
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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 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 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). The definition of a legal guardian does not apply to agency providers, but does apply to the person actually rendering service to a participant. 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. Providers may also access information on the DPW website (www.dpw.state.pa.us) and the OCS (ODP Consulting System) website (www.odpconsulting.net). ODP delegates the responsibility to determine whether interested providers meet waiver provider qualification criteria, as outlined in the approved P/FDS 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 and as per the ODP-established provider qualification process, the provider is able to enter service information into the ODP Services and Supports Directory and enter into an ODP Provider Agreement.

Waiver participants have free choice of willing and qualified waiver providers to provide needed services in the participant's approved ISP.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new providers, by provider type, that meet required licensure and/or certification standards and/or other State standards prior to furnishing waiver services.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers offering a new service that meet required licensure and/or certification standards and/or other State standards prior to them furnishing waiver services.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS

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Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers, by provider type, that continue to meet required licensure and/or certification standards and/or other State standards.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of Supports Coordination Organizations that meet all State standards prior to furnishing waiver services.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 Number and percent of Supports Coordination Organizations that continue to meet all State standards.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of licensed providers, by provider type, meeting provider training requirements.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
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<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties

responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

ODP has developed processes to track and ensure providers are qualified prior to furnishing waiver funded services:

- When Administrative Entities initially and/or continually qualify providers, dates of qualification are entered by AEs into HCSIS and notices are generated to providers verifying qualification status. On an ongoing basis, the ODP’s Bureau of Supports for People with Intellectual Disabilities reviews a Provider Qualification Status Report obtained from HCSIS to track qualification status of individual providers.
- A provider is not assigned a rate within HCSIS prior to the entry of a date all State standards have been met and the provider is deemed qualified. As a consequence, the provider cannot be included in the development of an ISP and will be unable to submit claims for waiver funded services.
- The ODP’s Bureau of Supports for People with Intellectual Disabilities staff verifies in HCSIS that a new provider is qualified before they forward the provider’s application for enrollment in PROMISE™ to the PROMISE™ Provider Enrollment Unit.
- As part of their process to authorize services in the ISP, Administrative Entities are expected to check in HCSIS that providers are qualified prior to authorization of services.

ODP’s Licensing Staff requires and follows up on Plans of Correction prepared by licensed providers who receive citations when training requirements are not met.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ODP is working with National Quality Enterprise (NQE) on its Quality Improvement Strategy and any changes

that may be needed by July 1, 2012.

a. Using data elements identifying providers, dates of application, dates of qualification, ODP will prepare reports summarizing the number of new providers (denominator) and the number of new providers meeting all State standards prior to delivering services (numerator) for the time period involved, the number of providers due for annual verification of qualification (denominator) and the number of providers that have received annual verification of qualification by the expected date (numerator) for the time period involved. ODP's Bureau of Supports for People with Intellectual Disabilities will review the reports on a quarterly basis by January 2011.

b. Using data elements identifying non-licensed providers, dates of application, dates of qualification, ODP will prepare reports summarizing the number of new non-licensed providers (denominator) and the number of new non-licensed providers meeting all State standards prior to delivering services (numerator) for the time period involved, the number of non-licensed providers due for annual verification of qualification (denominator) and the number of non-licensed providers that have received annual verification of qualification by the expected date (numerator) for the time period involved. ODP's Bureau of Supports for People with Intellectual Disabilities will review the reports on a quarterly basis by January 1, 2011.

c. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

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.

A \$26,000 per person per fiscal year total limit is established for all P/FDS Waiver services, with the exception of Supports Coordination.

ODP originally established the dollar limit as an individual cost limit. The original individual cost limit for the P/FDS Waiver was \$20,000. This limit was determined through the review and analysis of statewide expenditure information and information resulting from a survey of a sample of County MH/MR Programs. The expenditure information included the costs of adult training facilities, community employment,

vocational facilities, and family support services for non-waiver participants residing in non-licensed residential settings. The resulting combined average of the costs was approximately \$9,000 per person per year.

A follow up survey was completed with a sample of County MH/MR Programs to evaluate whether current expended funds were fully meeting the needs of the non-waiver participants. Based on the results of these surveys, ODP estimated an actual per person average cost of \$15,000 per year to fully meet the needs of people not residing in licensed residential settings. The original \$20,000 per person per year cost limit was established to allow services for participants with costs above the average.

The per person annual cost limit has been increased through waiver amendments over the past several years, as cost of living adjustments have been included as part of Pennsylvania's enacted Budget.

In fiscal year 2007/2008, Supports Coordination was added to the P/FDS as a waiver service, and the individual cost limit was changed to a limit of a set of services. The limit applies to all P/FDS Waiver services, with the exception of Supports Coordination. The limit will be increased in future fiscal years as per Pennsylvania's enacted Budget.

As per the Operating Agreement between ODP and AE's, the AE may only enroll new applicants into the P/FDS Waiver if the participant's current assessed needs can be met within the individual cost limit, or if needs not met within the cost limit will be met using non-waiver resources and/or supports. The AE may not enroll new applicants into the P/FDS Waiver if there is an outstanding health and welfare need that cannot be met within the individual cost limit. An individual needs assessment is conducted to identify services that the person may require to meet their needs. If the assessment indicates services in excess of the individual cost limit, the person may not be enrolled in the P/FDS Waiver unless the excess needs will be met through non-waiver resources and/or supports. If waiver enrollment is denied, the AE is responsible to provide the participant with their fair hearing rights, and the participant may appeal the decision. If the individual is enrolled in the P/FDS Waiver, they are informed at enrollment of the total limit, and that it applies to all P/FDS Waiver services except Supports Coordination.

P/FDS participants who experience a change in needs that results in service needs in excess of the individual cost limit may be transferred to the Consolidated Waiver. The AE, with the approval of ODP, may transfer participants with current, emergency needs in excess of the P/FDS cap if the AE already has been allocated sufficient waiver capacity and funding by ODP. If the AE does not have sufficient waiver capacity and funding to transfer a P/FDS participant with unmet needs to the Consolidated Waiver, the AE is to contact ODP to request additional waiver capacity and funding to transfer the participant.

P/FDS participants with needs in excess of the individual cost limit are also informed of other funding options for needed services, including state-only dollars and third party insurances. Participants are also referred to other services and supports in their communities.

- 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 conflict-free requirements 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 Customer Service calls. This log includes the nature of the complaint and allows ODP to conduct periodic reviews for any apparent conflict-free issues.
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 as part of the AE Oversight Monitoring 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. Via HCSIS, the ODP Regional Offices review incidents as well as the outcomes of investigations per the ODP Incident Management policies. 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.

6. ODP has information from monitoring that is conducted by supports coordinators using a standardized monitoring tool and entered into HCSIS. Monitoring forms are reviewed as part of ODP's oversight of AE's.

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 authorize any waiver provider that has a signed ODP Waiver Provider Agreement, if a waiver participant and/or their representative requests the services of such provider, and the provider agrees to serve the waiver participant.

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 Organization, 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(s) 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 preferences, strengths, and needs. If the person uses an alternate means of communication or if his or her primary language is not English, the planning and information gathering process needs to take this into account so accurate information can be gathered from the person and can be provided to the person.

The individual and his or her family, friends, and team develop Outcome Summaries and Actions to support the individual's assessed needs and personal goals. After the development of Outcomes, needed 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.

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, 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 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. ISP's address assessed needs, through waiver services or other means.

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 needed services, supports, and providers are identified. Information from the meeting is then documented in HCSIS, the ISP is approved and services are 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. Service providers 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, approved and authorized prior to the implementation of services. ISPs must be updated at least 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
- 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:

- Participating in the assessment process
- Completing assessments
- Sharing information
- Assuring information is in the completed ISP
- Participating in ISP meetings
- Implementing recommended services
- Reviewing ISP 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 ISP, the supports coordinator is responsible for ensuring the individual and all team members receive a copy of the finalized plan. Service providers have electronic access to the services they are authorized to render through HCSIS.

(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. Assessments are being completed by an independent contractor. The contractor 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. Information gathering should include physical development, communication styles, learning styles, educational background, social/emotional information, medical

information, personality traits, environmental influences, interactions, preferences, 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 may be 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 P/FDS 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 welfare. 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.

(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 ODP 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 as per the final ISP. The ISP includes the authorized services, outcome(s) attached to each service, and authorization dates, as well as the designated provider.

(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 (every 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 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, 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 for participant directed services.

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.

Providers record services information in the Services and Supports Directory (SSD). Information from the SSD on qualified providers for needed services is 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 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

D-1: Service Plan Development (8 of 8)

- 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 in HCSIS and it is submitted 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 statewide AE Oversight Monitoring Process, which 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; and
- Information from IM4Q, supports coordination monitoring, and incident management are reviewed at ISP meetings, and any outstanding issues are addressed.

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 be reviewed as part of the ODP Service Review procedures for the review of formal fair hearing requests that involve denial, reduction, suspension, or termination of waiver services for P/FDS 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 Monitoring process. 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.

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 §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager

Other

Specify:

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 P/FDS Waiver who ARE receiving a monthly service, the supports coordinator shall conduct monitoring at the following minimum frequency:

* For waiver participants living with a family member, the supports coordinator shall contact the waiver participant at least once every three (3) calendar months and shall conduct a face-to-face monitoring at least once every six (6) calendar months. At least one face-to-face monitoring per calendar year must take place in the participant's home.

* For waiver participants in any other living arrangement, including but not limited to their own home, Personal Care Homes, or Domiciliary Care Homes, the supports coordinator shall conduct a face-to-face monitoring at least once every three (3) calendar months and shall contact the waiver participant at least once every calendar month. At least one of the face-to-face monitoring visits every six (6) calendar months must take place in the waiver participant's home.

Deviations of the minimum monitoring that involve monitoring at a frequency and location that differ from the above requirements are permitted for participants living with a family member 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 two contacts

per calendar year and one face-to-face visit per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be approved by ODP.

For PFDS waiver participants who do NOT receive at least one waiver service each calendar month, ODP requires the following monitoring frequency by the supports coordinator, regardless of the participant's living arrangement:

* Contact at least once every calendar month; and

*A face-to-face monitoring contact at least once every three calendar months. 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.

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 conflict-free requirements 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 authorize any waiver provider that has a signed ODP Waiver Provider Agreement, if a waiver participant and/or their representative requests the services of such provider, and the provider agrees to serve the waiver participant.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of waiver participants who have all assessed needs addressed in the ISP through waiver-funded services or other funding streams, divided by the number of ISPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who attended their ISP meetings.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify:

	Every 6 months
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Performance Measure:
Number and percent of cases in which team members are invited to ISP meetings.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
 Number and percent of ISPs in which service frequency was indicated.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
 Number and percent of waiver participants with services authorized within 45 calendar days of the Waiver/Program Enrollment Date.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of ISPs where the AE authorized services consistent with the service definition.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose annual ISPs (annual review update) were revised and approved within 365 days of the prior annual ISP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of waiver participants whose ISPs are updated/revised as necessary to address changes in need as indicated in the supports coordination notes, monitoring reports, or the ISP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who received services and supports that are in the approved ISP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each)</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<i>that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number and percent of waiver participants who indicated they received the services they need.

Data Source (Select one):
Participant/family observation/opinion
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Independent Monitoring for Quality sample
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants where a signed and dated service delivery preference form (DP 459) is completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of waiver participants where documentation indicates choice between and among services was offered.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS, AE Reports, AEOM

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of waiver participants where the Supports Coordinator reviewed different types of services that might be available.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Seven percent of waiver participants
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ODP, AEs, and SCOs participate in remediating individual problems in the development, implementation, and monitoring of service plans.

ODP remediates non-compliance with service plan waiver assurance requirements through the AE Oversight Monitoring Process, which involves the review of a statistically significant sample of ISPs. If individual problems surface through the AEOMP review of individual records, ODP Regional Office staff works with the AE to develop a remediation plan. The remediation plan includes SCOs where appropriate. Through the validation process, the Regional Office follows up to ensure that issues have been addressed. ISPs also are reviewed as part of the Service Review Process when there is a fair hearing request that involves the denial, reduction, suspension or termination of waiver services for P/FDS Waiver participants. As a result of any Service Review, ODP will direct the AE to ensure any needed changes to the ISP are made.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ODP is working with National Quality Enterprise (NQE) on its Quality Improvement Strategy and any changes that may be needed by July 1, 2012.

ODP has developed a report that reflects utilization of services by individual waiver participants and plans to issue instructions and provide training for its use by SCOs and AEs by January 2011 to ensure that planned services are being delivered as authorized and if not corrective action is taken.

ODP is issuing a policy including a standard form and documentation requirement that will be used to validate that choice of provider and service were offered to the individual and reviewed and discussed with the team. For annual plans completed on or after January 2011, ODP intends to use the form during AE Oversight reviews to ensure the assurance was met.

In order to track timeliness with annual ISP planning and development requirements, ODP has created management and operational reports in HCSIS, including ISP 365 Day Detail Report, Critical Revision Report, Fiscal Year Renewal Compliance Report, and Review Date Compliance Report, and plans to institute a process to use the reports to ensure compliance and address any areas of noncompliance by July 1, 2010.

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 needs, which can be incorporated through natural and paid 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, surrogate, 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 necessary throughout the year.

The SCO, SC, AE, and the FMS providers share the role to provide information to participants on the ODP self-directed options. The roles and responsibilities are included in the ODP policies for participant directed services or any approved revisions. All participants must be provided information about the ODP self-directed options and the services that are identified as Participant Directed services (PDS). All participants who reside in their own private home or the private home of a relative or friend are offered the opportunity to exercise choice and control over participant directed services and the qualified support services workers they hire to render those services. The list of PDS is included in Appendix E-1-g. The services that are identified as Participant Directed Services are communicated annually by ODP through Informational Packets. The information is also posted at: <http://www.odpconsulting.net>.

Participants are able to self-direct through the utilization of a FMS organization. Participants may select one of two FMS models, the Agency with Choice (AWC) or Vendor Fiscal/Employer Agent (VF/EA) FMS models. The AWC FMS model is available through locally based AWC FMS providers. In the AWC model, the AWC FMS provider is the "Employer of Record" of qualified support service workers. Through this model, participants or their surrogate functions as the Managing Employer and work in a joint employer arrangement with the AWC FMS to fulfill responsibilities such as but not limited to:

1. Recruit and refer qualified support service workers to the FMS for hire;
2. Participate in training of workers;
3. Determine worker schedules;
4. Determine worker responsibilities; and
5. Manage the daily activities of workers.

In the AWC model, the FMS is responsible for functions such as but not limited to:

1. Hiring qualified support service workers referred by participants/surrogates;
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 PROMISE for services authorized and rendered.;
6. Preparing and disbursing payroll checks;
7. Providing workers compensation for workers;
8. Providing a variety of supports to participants/surrogates, to include employer skills training and development of a worker registry; and
9. Conducting worker training as needed or requested.

The VF/EA FMS model is provided through a statewide entity on contract with ODP. In the VF/EA model, the participant or their surrogate is the “Employer” of qualified support service workers. Through this model, the participant or their surrogate has responsibility to fulfill functions such as but not limited to:

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 VF/EA model, the FMS is responsible for functions such as but not limited to:

1. Functioning as the employer agent on behalf of the participant/surrogate;
2. Withholding, filing, and paying Federal employment taxes, State income taxes, and workers compensation on behalf of the participant/surrogate;
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 employers with informational materials for enrollment of the employer and the workers into the VF/EA FMS model.

All participants functioning as the Employer or managing employer are afforded budget authority which enables them to designate the hourly wage paid to each qualified support service worker, as long as that hourly rate of pay is within the wage range established by ODP. All participants self-directing their services have the flexibility to shift funds between authorized participant directed services with prior notification to their Supports Coordinator.

All participants who use FMS services have the right to receive those services in accordance with the guiding principles of self-determination. This means that participant-directed services must be provided in a manner that affords participants and their surrogates, if applicable, choice and control over the services they receive and the qualified service support workers, vendors and providers who provide them.

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

Individuals who live in a private residence may self direct the identified participant directed services. Individuals who live in licensed and unlicensed residential settings may not self-direct.

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.

ODP has developed and required distribution of standard participant directed information. That standard information is included in the ODP, Pennsylvania Guide to Participant Direction, ODP policy bulletins on participant direction and the ODP approved statewide Vendor Fiscal/Employer Agent start up packet. Participants are provided with this information, as well as technical assistance on participant direction through the SCO, SC, AE and FMS providers. The AE is responsible to ensure that waiver applicants are provided with information about participation direction during intake and enrollment. Supports Coordinators and Supports Coordinator Organizations are responsible to 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. FMS providers, supports brokers) as necessary. In addition, ODP sponsored statewide training on participant direction and the available FMS models at AE Academy sessions and has offered statewide training to the SCO organizations and the AEs. Participants can also receive information and training on participant direction upon request from the supports coordination organization, AE, FMS, ODP and "The Partnership".

Participants may also utilize Supports Broker Services through the Waiver as needed to plan, manage, and organize community resources (see Appendix C-3 for additional details).

Participants who utilize AWC FMS may receive assistance in employer-related responsibilities from the AWC FMS provider. Participants who utilize the VF/EA FMS may receive assistance from the statewide VF/EA FMS and the supports broker when utilized.

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 surrogate assist in hiring and managing qualified support service workers who are paid through an FMS. If a surrogate is desired by the participant, the surrogate 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.
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 surrogate 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 authorized surrogate – If the participant desires a surrogate, but is unable to identify one of the above, the participant, along with their supports coordinator, shall identify an appropriate surrogate. The adult surrogate should have knowledge of the participant's preferences and values. The FMS is responsible to ensure that the selected surrogate agrees to fulfill the responsibilities of surrogate by ensuring the review and completion of the ODP standard agreement form.

A surrogate may not receive payment for this function. In addition, a surrogate may not receive payment for any Waiver services the surrogate provides to the participant they are surrogate for, with the exception of mileage reimbursement for Transportation.

The FMS must recognize the participant's surrogate as a decision-maker, and provide the surrogate with all of the information, training, and support it would typically provide to a participant who is self-directing. The FMS must fully inform the surrogate of the rights and responsibilities of a surrogate. Once fully informed, the FMS must have the surrogate review and sign an ODP standard agreement form, which must be given to the surrogate and maintained in the participant's file. The agreement lists the roles and responsibilities of the surrogate; state that the surrogate accepts the roles and responsibilities of this function; and state that the surrogate will abide by ODP 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 surrogate not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by supports coordinators, their supervisors, FMS, 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
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Accessibility Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homemaker/Chore	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home and Community Habilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Accessibility Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Companion	<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:

Financial Management Services (FMS) are available through the AWC and VF/EA FMS models. AWC FM services are available through locally based AWC FMS providers. The locally based AWC FMS providers were identified by ODP to provide financial management services to participants in each AE.

VF/EA FM Services are available through a statewide entity on contract with ODP. The statewide VF/EA FMS organization was selected through a Commonwealth Invitation for Bids process.

FM services must be provided in accordance with applicable US IRS rules and regulations, US Department of Labor and state and local rules and regulations pertaining to support service workers, employer agents, and ODP policies.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Effective July 1, 2009, AWC FMS providers receive payment for the administrative cost incurred for providing the AWC FM services and receive reimbursement for the delivery of authorized PDS waiver services based on claims made to PROMISE. Payment is made directly from the Pennsylvania Treasury. Administrative rates have been established by ODP with the AWC FMS providers as a monthly fee per participant. The established administrative monthly fee per participant must be applied consistently with each participant within the AWC FMS provider.

ODP contracts with one statewide Vendor Fiscal FMS. ODP pays the statewide Vendor Fiscal FMS a monthly fee per participant for the administrative costs incurred. The VF/EA will bill for authorized and delivered PDS services through PROMISE and will receive payment directly from the Pennsylvania Treasury.

- 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:

	<input type="button" value="▲"/> <input type="button" value="▼"/>
--	--

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:

Receives and disburses funds for the payment of vendor services as follows:

The statewide VF/EA FMS and AWC FMS providers may subcontract for goods needed for a participant that have been designated as PDS vendor services. In these situations, the VF/EA and AWC FMS is responsible to ensure that subcontracted entities meet all applicable provider qualification standards for the service. In addition, the VF/EA and AWC FMS must complete the following activities for the service offered/rendered:

- Enroll in PROMISE as the provider;
- Ensure the requirements of Appendix C, including provider qualification standards, are met;
- Cooperate with provider monitoring conducted by ODP or one of its designees;
- Cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring when necessary; and
- Maintain documentation on service delivery.

The cost of the good or vendor service must be the same as charged to the general (or self-paying) public. Any administrative charge is included in VF/EA and AWC FMS monthly per participant fee.

- 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 locally based AWC FMS providers are monitored by AEs as per the AE Operating Agreement and Bulletin 00-08-08, or any ODP approved revisions. In addition, AEs are responsible to conduct ongoing performance monitoring of AWC FMS providers as per the AE Operating Agreement. AEs are also responsible to ensure that supports coordinators monitor the services and supports paid for through the FMS, at the minimum frequency established by ODP (see Appendix D-2: a).

The statewide VF/EA FMS organization is monitored on an ongoing basis by ODP. ODP monitors the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. ODP also monitors claims submitted to PROMISE by the FMS. AE's are also required to report any issues with the statewide FMS organization'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 (SC) and Supports Coordination Organizations (SCO) must provide participants with the ODP developed or approved information such as the , Pennsylvania Guide to Participant Direction, ODP policy bulletins on participant direction, the ODP established wage ranges and the ODP approved statewide Vendor Fiscal/Employer Agent (VF/EA) start up packet. The SC and SCO provide a basic review of this information and provide contact information for the statewide VF/EA on contract with ODP as well as the designated Agency with Choice (AWC) in their Administrative Entity. The VF/EA and the AWC provides more detailed information on the enrollment process and all forms that are required to be completed and the responsibilities associated with the VF/EA or AWC option. The SC or SCO is required to share the above 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. FMS providers and organizations, supports brokers) 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
Education Support Services	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Home Finding	<input type="checkbox"/>
Unlicensed Residential Habilitation	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Specialized Supplies	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Supported Employment - Job Finding and Job Support	<input type="checkbox"/>
Home and Community Habilitation	<input type="checkbox"/>
Vehicle Accessibility Adaptations	<input type="checkbox"/>
Supports Coordination	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Nursing Services	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Companion	<input type="checkbox"/>
Transitional Work Services	<input type="checkbox"/>
Supports Broker Services	<input checked="" type="checkbox"/>
Licensed Day Habilitation	<input type="checkbox"/>
Therapy 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 or their surrogates who function as the “Employer” may access orientation and functional training or may obtain enrollment and informational materials from the statewide VF/EA FMS organization on contract with ODP. The informational materials made available to participants and/or their surrogates by the statewide VF/EA FMS includes a comprehensive Enrollment Packet referred to as the “start up packet”.

Participants or their surrogates who function as the “Managing Employer” may access orientation, functional and ongoing training or may obtain enrollment and informational materials from the AWC FMS provider in their AE. The informational materials made available to participants and/or their surrogates by the AWC FMS, includes, the AWC FMS bulletin and the Pennsylvania Guide to Participant Directed Services (PA Guide to PDS).

AE’s SCOs, ODP and the AWC FMS share the responsibility of sharing the ODP PDS informational packet known as the PA Guide to PDS. Additional trainings can be requested from "The Partnership".

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)

- 1. 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 a participant or surrogate functioning as the “Employer” voluntarily terminates themselves from the VF/EA FMS participant directed model, the supports coordinator will provide the participant with options to choose the AWC FMS model or agency-based service options to meet their needs. Both participant-directed services and traditional service models provide similar services to meet the participant’s needs. The supports coordinator is responsible to work with the participant, surrogate, and ISP team to ensure an effective transition between participant directed and traditional services so that there are no gaps in service.

If a participant or surrogate functioning as the “Managing Employer” voluntarily terminates themselves from the AWC FMS participant directed model, the supports coordinator will provide the participant with the option to choose the VF/EA FMS model or agency-based service options to meet their needs. The supports coordinator is responsible to work with the participant, surrogate, and ISP team 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 participant or their surrogate is suspected or convicted of Medicaid fraud or if the participant fails to meet the conditions of their signed agreement. Involuntary termination will also occur if there is sufficient evidence through supports coordination monitoring that the participant’s assessed needs are not being met as a result of the performance by the employer or managing employer. All involuntary terminations must be approved by the appropriate ODP Regional Office.

If a participant or surrogate functioning as the “Employer” is involuntarily terminated from the VF/EA FMS participant directed model , the supports coordinator will provide the participant with options to choose a new surrogate who will fulfill the surrogate functions as required, the Agency with Choice FMS model or agency-based service options to meet their needs.

If a participant or surrogate functioning as the “Managing Employer” is involuntarily terminated from the AWC FMS participant directed model, the supports coordinator will provide the participant with options to choose a new surrogate who will fulfill the surrogate functions, and 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	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	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="1500"/>
Year 4	<input type="text"/>	<input type="text" value="1500"/>
Year 5	<input type="text"/>	<input type="text" value="1500"/>

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:

The participant or the participant's representative (surrogate) functions as the co-employer (managing employer) of their workers who provide the authorized services. The Agency With Choice (AWC) is the employer of record of the staff. The AWC performs the employer of record functions, payroll and human resources functions. The AWC provider is available to assist the managing employer with their employer-related responsibilities. When needed and when authorized a Supports broker also may assist the managing employer with their employer-related functions.

Private entities function locally as AWC FMS providers. Under the AWC FMS model, the FMS and the participant/surrogate must work together effectively as a team to: 1. Offer a high level of choice and control to participants/surrogates, and 2. Minimize any employer liability for the FMS and the participant/surrogate. The focus of the AWC FMS is to afford participants/surrogates with the ability to be effective managing employers (The FMS is the "Employer of Record"; however, the participant/surrogate engages in managing functions, including recruiting and referring workers to the FMS for hire, managing worker day-to-day responsibilities and schedules, and discharging workers from the home when necessary.). The AWC FMS must fully embrace and apply the philosophies of self-determination and self-directed support services by providing participants/surrogates with a high level of choice and control over the support services they receive and the workers who provide them. AWC FMS providers are responsible to develop and maintain a system and written policies and procedures that reflect ODP policy and afford participants/surrogates with the ability to recruit, interview, and select qualified support service workers for hire by the FMS; as well as the ability to be managing employers.

The AE is responsible to ensure that participants/surrogate utilizing the AWC FMS 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/surrogates may discuss concerns regarding limits on choice and control with supports coordinators, supports coordination supervisors, AWC FMS and AE's. Participants/surrogates may also contact ODP through the Regional Office or the ODP Customer Service Number (1-888-565-9435).

- 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 a participant support plan to meet the participant's assessed needs. The participant budget is established based on the waiver services, units, and cost per unit included in the plan.

AEs must approve and authorize plans in accordance with the AE Operating Agreement. The FMS will have access to HCSIS to review and print the approved and authorized participant-directed services for which they will be making payment. This includes the total units and total dollars identified for the participant directed services. The participant's ISP must include the service procedure code, the total units and the total dollars for each authorized participant directed service.

ODP has established wage ranges/rates for the following participant directed services.: Unlicensed Home and Community Habilitation, Supported Employment, Supports Broker Services, Homemaker/Chore, Companion, and Respite. The fees for Home Accessibility Adaptations, Vehicle Accessibility Adaptations, Adaptive Appliances/Equipment, Specialized Supplies, Respite Camp and Transportation (mile and public) are based on actual costs.

The participant directed service, total units and total dollars are used to calculate the participant directed portion of the ISP. Information packets on the identified participant directed services and wage ranges/rates are distributed annually and published on the ODP Consulting website (www.odpconsulting.net).

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 participant or their designated surrogate exercises budget authority as follows: recruits and interviews support service workers, hires or refers for hire support service workers, negotiates wages for the support service workers within the ODP established wage ranges, identifies qualified small unlicensed providers and vendors to provide needed services, manages authorized units and funds associated with the authorized units, reviews monthly utilization statements provided by the FMS, makes service adjustments based on need and the review of the utilization statements and collects, reviews, approves and submits all timesheets and invoices for payment by the FMS.

The supports coordinator informs the waiver participant of the approved and authorized services subsequent to the development and authorization of the plan. Participants may request an adjustment in their participant directed services through their supports coordinator to accommodate changes in need. If an ISP adjustment is denied or the participant's services are 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 services is monitored by the AE and the FMS provider or organization. The AE monitors expenditures through the review and payment of claims. AWC FMS providers 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 AWC FMS provides monthly statements to the managing employers so they can appropriately track utilization of services and the corresponding funds. The VF/EA FMS organization on contract with the State is responsible for invoicing services provided, and also processing and disbursing payroll checks, and is responsible to do so in accordance with the participant's authorized ISP. The VF/EA FMS organization records funds received and disbursed, as well as remaining balances for each participant. They also distribute monthly utilization statements to the employer.

Standardized ISP monitoring is used to identify and address potential service delivery problems, including those associated with over- or under-utilization of authorized services.

If issues, such as over-utilization or under-utilization, related to participant directed services are recognized, the supports coordinator and/or the FMS are responsible to promptly notify the employer of record or managing employer and the AE. The AE is responsible to review the situation and ensure that necessary plan and budget changes are made in a timely fashion, or to ensure appropriate notification of their findings are provided to the SC, employer of record, managing employer, FMS and ODP.

The statewide Vendor Fiscal FMS and locally based AWC FMS providers will also monitor the participant's and/or their surrogate's satisfaction with the participant-directed services they receive.

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 00-08-05, 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.

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 Bulletin 00-08-05.

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 ensure such services are implemented promptly, in accordance with ODP policies. The AE shall ensure the revision of the individual's ISP, authorize the services and document the start date of the services in HCSIS. In addition and in accordance with the AE Operating Agreement the AE is required to ensure services are implemented promptly. The AE must have a process to track decisions and timely implementation of the service review or BHA decision. If the AE recognizes delays in implementing the service[s], they shall notify ODP and shall request an extension from the ODP regional office. ODP has established a data base and tracking protocol to track AE compliance with this requirement.

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.

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:

ODP 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).

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 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 Supports for People with Intellectual Disabilities during normal business hours. The following information is specific to grievances and complaints. Individuals calling the 888 line with a complaint/grievance are logged into a database. After a call is entered in the database it is referred to ODP regional, or headquarters staff for resolution. Documentation of the resolution is entered into the database by the person assigned follow up for the call.

The second component of the grievance/complaint system is email. The DPW website provides customers the option to "contact ODP," once a customer 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.

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 and responded to accordingly.

Appendix G: Participant Safeguards

APPENDIX C - RESPONSE TO CRITICAL EVENTS OR INCIDENTS

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*
- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
 - No. This Appendix does not apply** (do not complete Items b through e)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **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. This includes physical abuse, psychological abuse, sexual abuse, verbal abuse, and improper or unauthorized use of restraint. Physical abuse is defined as 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 is an act, other than verbal, which may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual. Sexual abuse is 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 involves 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 is 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 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 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.

Incident Management Bulletin, 6000-04-01, requires that specific types of incidents be investigated by providers, AE’s, and/or ODP. Required investigations must take place promptly by a certified investigator. A certified investigator is a person who has been trained and received a certificate in investigation from ODP. Certified investigators are responsible to investigate incidents as per their standard training, and to enter a summary of their investigation findings in the HCSIS Incident Report. Corrective action for the incident must address any investigation findings.

- c. **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.
- d. **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 management approval within 30 days of 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 more as needed during 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 data to evaluate the effectiveness of interventions. Statewide analytical reports and 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 must 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 individuals 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.

- e. **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 adult training facilities (§2380) spell out requirements related to restrictive procedures. These regulations require that all adult training facility providers establish a restrictive procedure review committee as per the regulations outlined below:

§ 2380.154. 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 adult training facility (§2380) 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 55 Pa Code Chapter §2380 identifies 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. This policy is 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 Committee. The Positive Practices Committee reviews that appropriate services and supports are in place for individuals experiencing restraint applications.

The Statewide ODP Risk Management Workgroup (SRMW) is charged with monitoring, reviewing, and analyzing statewide incident data. This Workgroup is comprised of ODP Regional Risk Managers, the ODP Central Office Risk Management Director, Quality Initiative Leads, and Risk Management Support Staff. The SRMW uses previous year's data as a baseline or comparison during analysis. This allows data to be compared and enables the SRMW to identify patterns and trends. Once the comparison is made, the SRMW is able to make recommendations to ODP Leadership for statewide 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 monitoring tool.

They can use Health Care Quality Units (HCQUs) for support with regard to questions about medications. As part of 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 may exist 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

Appendix G-3: Medication Management and Administration (2 of 2)

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 licensed day services 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 for participants, as requested.

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 G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Total number of critical incidents.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of critical incidents, confirmed, by type.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of critical incidents investigated within the required time frame.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>

<i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of restraints reported, by type.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of physical restraint applications during which procedures specified in the Incident Management Bulletin, applying to all waiver participants, are not followed.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number and percent of medication errors, by type.

Data Source (Select one):
Medication administration data reports, logs
If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Percent of participants who ever feel afraid in their home, work place, day program, and neighborhood.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Independent Monitoring for Quality sample
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number of law enforcement incidents where the individual was a victim of a crime.

Data Source (Select one):
Critical events and incident reports
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation	Frequency of data aggregation and
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and analysis (check each that applies):	analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Percent of waiver participants that were a victim of a crime within the last year.

Data Source (Select one):
Critical events and incident reports
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of waiver participants with incidents where their rights were violated.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Administrative Entities, Waiver Providers (including Supports Coordination Organizations)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:

Number and percent of waiver participants who indicated they are treated with respect and dignity.

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		Independent Monitoring for Quality sample
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of hotline calls that are complaints.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of complaint calls by type: staff complaints, provider complaints, AE/county complaints.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percent of complaints where first contact occurred within 24 hours.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percent of people who ever feel afraid in their home, work place, day program, and neighborhood.

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Independent Monitoring for Quality sample
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Commonwealth approaches remediation using a layered method of evaluation. The following outlines how this happens for the vast majority of performance measures within the Health and Safety category.

G-1: Critical Incidents

For each critical incident the impact on the individual and his/her health and well being is evaluated by investigation by the party specified in the IM bulletin or other policy of what happened, what went wrong and how that can be changed to prevent the same occurrence in the future for that individual or another.

Remediation at the individual level occurs through training or technical assistance by a number of different entities including the provider, the AE, ODP, Health Care Quality Units (HCQU), and the Positive Practices Resource Team (PPRT).

When an incident is recognized or discovered by a provider, prompt action is to be taken by the provider initial reporter and point person to protect the individual's health, safety and rights. When an individual or family informs their supports coordinator (SC) 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) the SC is to immediately notify the service provider. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing a HCSIS incident report. When an individual or a family member informs the SC of an event that can be categorized as abuse or neglect and there is no relationship to the provider as specified in §6000.911 (b)(1)-(3) the SC will take prompt action to protect the individual. Once the individual's health and safety are assured the SC will ensure a certified investigator is assigned as necessary and file a HCSIS incident report. Within 24 hours of the submission of the first section of the incident report, both the designated AE and ODP review the incident to determine that appropriate actions to protect the individual occurred. As a result of the investigation if the event were founded, then a number of approaches might be taken.

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: appropriate action to protect the individual occurred; incident is categorized correctly; needed investigation occurred; proper safeguards are in place; and corrective action has, or will, take place. ODP completes a management review within 30 days of the AE's approval of the report. The management review will include all of the above including the AE's response to the incident. ODP is responsible to verify that the investigation was fully completed according to the incident closure protocol and that appropriate action has been taken.

The top layer is looking at events statewide. This sometimes involves individual events, but more likely involves looking at events in the aggregate. Individual critical event analysis may result in ODP issuing a statewide alert. Referrals to other government entities may come from the statewide level related to issues identified in data analysis or review of a single event.

G-2 Restraints

Restraints are reported by the provider and go to the AE and ODP for review. Patterns of restraints such as identifying participants that have a high number of restraints or identifying providers that frequently use restraints are then addressed in a number of different strategies.

Participants that have a high number of restraints will have a review done. This can be accomplished in many ways, for example through the PPRT process or by the AE asking the HCQU to review the participant's information as part of a clinical review. Individual remediation such as identifying reasons for behavior leading to restraint and ways to approach this in a different fashion using positive approaches would be a common result of such a review.

Regulations 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. ODP Bulletins support regulations and provide additional clarification on restraint documentation. Additionally, an ODP Bulletin outlines how the Commonwealth tracks incidents and includes expectations regarding development of provider and County/AE performance reports specifically on restraints.

Providers that frequently use restraints may be approached regarding any technical assistance, training and/or resources needed to decrease the use of restraints. This is done by ODP staff and may involve support from other resources, such as the HCQU.

G-3 Medication Administration Errors

Medication errors are reported through HCSIS which collects information on what happened using standard definition of medication errors; who made the error; what the individual response to the error was; and what the system response to the error was. In this manner the elements of the root cause analysis are outlined.

The root cause analysis looks at the underlying structure and trends and patterns in the area in order to identify provider policies that might impact on outcomes related to particular events or geographic patterns.

Remediation related to medication errors can occur in multiple ways from working individually with a staff person to rewriting and revising provider medication policies and practices. The latter is something that the HCQUs could provide technical assistance with.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ODP is working with the National Quality Enterprise (NQE) on its Quality Improvement Strategy and any changes that may be needed by July 1, 2012.

ODP intends to develop a database that will fully capture complaints in a manner that will facilitate easy analysis. Implementation of this new database is planned for July 1, 2012. ODP's current data collection system is built on a platform that is no longer in use and, therefore, cannot be revised. Until the new system is in place, ODP will maintain the current data collection system and will manually collect and analyze needed data.

Appendix H: Quality Improvement 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 Improvement 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 Improvement 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 Improvement 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 Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement 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 Improvement Strategy, including the specific tasks the State plans to undertake during the period 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 Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

ODP has developed Quality Oversight Groups in each of its four Regional Offices to review region-specific aggregate performance data in each of the six waiver assurance areas and a Community Services Quality Oversight Group to review statewide aggregate performance data in each of the six waiver assurance areas. ODP Regional Office Staff are assigned to participate in the compiling and analyses of aggregate data pertaining to their region, then join with ODP Central Office staff to compile and analyze data statewide. Regional analysis, conclusions, and recommendations are considered when statewide analysis is performed;

conclusions and recommendations proposing system-wide improvements are made by the Community Services Quality Oversight Group. Improvement activities prioritized and recommended by the Community Services Quality Oversight Group are presented to ODP's Quality Leadership Board for final approval.

ODP plans to continue to use this process to study aggregate performance data in each of the six waiver assurance areas on a routine, planned schedule that includes responsible staff for review of performance measures outlined in Appendices A, B, C, D, G, and I. Regional Office and Community Services Quality Oversight Groups will also track progress of assigned staff on completing activities listed in the Timelines of Appendices A, B, C, and D.

Information used for trending and prioritizing opportunities for system improvements is also 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.

ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. The recent system-wide change in financial operation and management of the waiver programs, for example, was implemented through the collaborative efforts of internal ODP staff in Central and Regional Offices, stakeholder groups including Administrative Entities, providers, consumers and families, other State agencies, and consultant groups. During this implementation, a separate oversight body specific to this initiative was developed to track progress and provide guidance, direction, and decision-making authority. Several additional groups were also chartered to perform specific functions, including development of policies and procedures, training and communications, and oversight of the operational implementation of the desired change. ODP plans to continue to involve internal staff and other stakeholders in the implementation of system improvements in consideration of the design change involved and specific input needed.

As part of its QMS, ODP plans to develop and publish an Annual Quality Management (QM) Report to provide information on the review and analysis of statewide data and performance and identify priorities for improvements.

Administrative Entities are required to develop and implement an Annual QM Plan that incorporates ODP's priorities and prioritizes the AE's opportunities for improvement related to compliance with waiver assurances. Where applicable, Providers and Supports Coordination Organizations are expected to collaborate with Administrative Entities in the implementation and evaluation of changes designed to achieve system improvements.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the State's targeted standards for systems improvement.

ODP uses a Plan-Do-Check-Act (PDCA) Model for implementing, monitoring, and analyzing the effectiveness of system design changes. Specific units within ODP are assigned responsibility for monitoring and analyzing the effectiveness of system design changes and providing periodic, routine reports on progress to the Community Services Quality Oversight Group. For example, beginning July 1, 2009 the Fiscal Unit is responsible for identifying problem areas related to the implementation of the new financial program design, including payment through Treasury and rate-setting methodology. Each week the volume of paid and denied claims, and the dollars associated with those claims are captured. The percentage of paid claims is expected to increase each month as providers become more familiar with ODP's billing rules. Total dollars paid weekly will be placed in a time series format for ODP staff review. All error status codes that have set during a week will be captured on this report in descending order sorted by volume. This report will be used by the ODP Claims Resolution Section to identify high volume Error Status Codes. A time series report will be generated. The assumption is that the percentage of claim denials will decrease over time. ODP's Central Office Fiscal Unit will provide quarterly reports to the Community Services Quality Oversight Group using aggregate data compiled as of July 1, 2009. Areas for further improvement related to these reports may be suggested by the Fiscal Unit, Regional Office staff, Executive Staff, and Community Services Quality Oversight Group. When improvement strategies are implemented, the Fiscal Unit will again track and evaluate their effectiveness.

Other potential problem areas associated with the implementation of Prospective Payment will also be identified beginning with the establishment of baselines during the base year of the transition (FY 2009-2010). Problem areas will be identified as over or under-spending patterns statewide. A problem area may be identified in comparing regions, AEs, or providers to each other or against statewide averages. A problem area may be a particular service pattern (e.g. authorized vs. delivered services). ODP staff will investigate and remediate based on the problem areas.

The Fiscal Unit will attempt to identify patterns and trends from the aggregation of data across the State, across AEs, and across providers. Initial baseline amounts will be determined in the first months and year(s) in an effort to create meaningful comparisons. Fiscal Unit reviewers may flag AEs or providers who show a predetermined % difference (e.g. 10%) between targeted and actual amounts. Outlier results will be researched further. Regular reports will be made available to Executive Staff. Regional Staff will be alerted to outlier results and may be asked to investigate discrepancies.

ODP will apply the model in use by the Fiscal Unit to monitor and evaluate the effectiveness of additional system-wide changes.

Beginning in 2010, ODP will also evaluate the implementation of AEs' Annual QM Plans containing their targeted improvement activities and provide feedback to each AE.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

On an annual basis, considering input from stakeholders and Quality Oversight Groups, ODP's Quality Leadership Board will assess program and operational performance as well as ODP's Quality Management Strategy. Results of this review may demonstrate a need to revise ODP's QMS, 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.

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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Data Source (Select one):
Financial records (including expenditures)
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers who submitted cost reports.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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Performance Measure:
Number and percent of providers whose cost reports were accepted.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Other
Specify:

Performance Measure:
Number and percent of rates issued that were appealed.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

Performance Measure:
Number and percent of providers with audits submitted by the due date.

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The ODP Claims Resolution Section operates daily and is responsible to:

- Respond to phone and email inquiries regarding claim issues
- Document claim inquiries
- Research claims as a result of claim inquiries
- Identify claim errors from claims research
- Communicate resolution instructions to ODP providers who make inquiries
- Identify recurring claims' issues
- Conduct an impact analysis
- Communicate recurring claims' issues to the appropriate parties
- Implement a solution to issue by submitting change orders, data maintenance requests, and/or reference file requests as system issues are identified and need correction
- Work with contractors to correct issues
- Develop time sensitive communications for the provider community (Alerts, Announcements, Informational Memos, Informational Packets)
- Resolve suspended claims.

Beginning July 1, 2009 problem areas will be identified and compared to a norm which will be established in the base year of the transition to payment through Treasury (FY 2009-2010). The problem area may be identified in comparing regions, AEs, or providers to each other or against statewide averages. The problem area may be a particular service pattern (e.g. authorized vs. delivered services). ODP staff will investigate and remediate based on the problem areas.

Each week the volume of paid and denied claims, and the dollars associated with those claims are captured. The assumption is that the percentage of paid claims should increase each month as providers become more familiar with ODP billing rules. Total dollars paid weekly will be put in a time series format for ODP staff review. All error status codes that have set during a week will be captured on this report in descending order sorted by volume. This report will be used by the ODP Claims Resolution Section to identify high volume Error Status Codes. A time series report will be generated. The assumption is that the percentage of claim denials will decrease over time.

The Fiscal Unit will attempt to identify patterns and trends from the aggregation of data across the State, across AEs, and across providers. Initial baseline amounts will be determined in the first months and year(s) in an effort to create meaningful comparisons. Regular reports will be made to Executive Staff. Regional Staff will be alerted to results and may be asked to investigate as needed.

For providers who submitted a cost report but it was not accepted last year and are again having difficulty completing the cost report, ODP will contact those providers directly and offer more intensive cost report training. For providers who were notified of corrections needed through the desk review process, there will be

a web site for technical assistance as well as a help line which both providers and AEs can use to resolve problems. Problems with the cost reporting process will be identified by monitoring the number of providers who are having difficulty completing the cost report and are contacting the help line for assistance as well as the complexity of the questions asked.

For providers who did not submit the financial audits by the deadline date of 3/31 or inform ODP they are having difficulty meeting the date, the provider will be contacted. For providers who have adjustment based on the financial audits and submit them by the deadline date of 3/31, they will be contacted to discuss how these adjustments will impact the cost report-based rates.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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).

Beginning July 1, 2009, ODP is in the process of transitioning to a prospective payment system (PPS) that will be fully effective July 1, 2011. During the two-year transition period, the PPS is comprised of two components: rate-setting and revenue reconciliation.

There are several approaches to set rates under the PPS, depending on the type of service: cost-based rates, fee

schedule rates, outcome-based payment for goods and services, and participant-directed service rates.

1. Cost- Based: The cost-based rates are developed as follows:

- Cost and utilization data is collected annually using a standardized cost report as prepared and submitted by providers of service. Cost reports undergo a desk review in which the reported data is analyzed by ODP or its designee for completeness and accuracy based on cost report instructions and standardized review procedures.
- Cost report data is adjusted to reflect changes in the service definitions, if necessary, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect.
- For providers whose cost reports are not approved and for providers who do not submit a cost report, ODP assigns rates in accordance with a standardized methodology that is communicated to each provider in the notice informing the provider of its payment rates. Providers are assigned a rate based on a percentile within the range of rates established through analysis of the approved cost reports. Providers that do not attempt to submit a cost report are assigned the lowest statewide rate for the service(s) based on provider cost report data. Providers that attempt, but fail to successfully upload a cost report by the required due date, are assigned a rate representing the 12.5th percentile of the procedure code rates based on aggregate provider cost report data. Providers that submit a cost report by the required due date, but fail to comply with all cost report instructions identified through a desk review, are assigned a rate representing the 25th percentile of the procedure code rates based on aggregate provider cost report data. New providers that enroll and qualify to provide services after the cost report process is complete for that period will have no cost history and, are therefore, assigned the area average rate for the service(s).
- Approved provider cost reports that are identified as an outlier, undergo a review conducted by ODP. The outlier reviews are performed to determine whether adjustments are needed to address variation among providers' unit costs. The outlier threshold(s) are based on cost report data and are established for each service with at least 20 data points to be either one or two standard deviations outside the average unit cost. The outlier review process is conducted as follows:
 - o Statistical ranges for each service are developed from aggregate provider cost report data.
 - o Unit costs that are above or below the established statistical range will be flagged as outliers.
 - o Unit costs flagged as outliers that are determined to be within +/- 5% of the provider's prior year rate for a service, will be accepted.
 - o Unit costs flagged as outliers that are not within +/- 5% of the provider's prior year rate for a service will undergo further review by ODP's evaluation of the Individual Service Plans (ISPs) and the following will apply:
 - If the outlier costs are justified by the ISP review, the outlier rate will be accepted.
 - If the outlier costs are not justified by the ISP review, the outlier rate will be adjusted to be within the established statistical range.
- Prior to the effective date of rates, the methodology for calculating unit costs that includes the outlier review process and rate assignment process are communicated to the provider in the provider rate notice and in a public notice published in the Pennsylvania Bulletin. Other standard ODP communications are distributed that outline the methodology for calculating unit costs that includes the outlier review process and the rate assignment process.
- Since the cost report data is from a historical time period, a Cost of Living Adjustment (COLA) is applied as appropriated by the General Assembly.
- A rate adjustment may be applied during the rate development/assignment process. This is called a Rate Adjustment Factor (RAF). A RAF is done prospectively and is based on an analysis of provider expenditures compared to the budget appropriation amount.
- Prior to rates being established each fiscal year, the outlier analyses, COLA adjustment, and a Rate Adjustment Factor (RAF) are calculated and applied to all cost-based rates.
- The rate-setting methodology, including the cost report review, outlier analyses, COLA adjustment, RAF and rate assignment process, is communicated in advance of the effective date through a public notice published in the Pennsylvania Bulletin and in the individual provider rate notice.
- The individual provider rate notice includes information on the process to contact ODP on questions and concerns related to the provider rate notice. Providers have the right to appeal as outlined in 55 PA Code Chapter 41. The appeal language is included in the individual provider rate notice.

2. Medical Assistance Fee Schedule: Select services for placement on the fee schedule are identified by ODP prior to July 1 of each year. The fee schedule rates account for variations among geographic areas as designated by ODP.

- Rates for the following services or components of a service are on the Medical Assistance fee schedule effective July 1, 2009: Home Finding, Behavioral Support, Homemaker/Chore, Physical Therapy, Occupational Therapy, Behavior Therapy, Speech/Language Therapy, Visual/Mobility Therapy, Nursing, Companion, Older Adult, Supports Broker and Residential enhanced staffing (Supplemental Habilitation and Additional Individualized Staffing).
- Each year additional services are considered for the fee schedule.
- Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change.

3. Outcome-based payment for goods and services:

- ODP reimburses outcome-based services, such as Home and Vehicle Accessibility Adaptations, Assistive Technology, Supplies, Education Support, Public Transportation and Respite Camp based on the cost charged to the general public for the good or service.
- Transportation Mileage is reimbursed at the federal reimbursement rate.

4. Participant-directed service rates: Rates for participant-directed services are established through the development of standard wage ranges (Vendor Fiscal/Employer Agent model) and a fee schedule (Agency with Choice model). The Vendor Fiscal/Employer Agent and Agency with Choice wage ranges are issued by ODP prior to July 1 each year in a standard ODP communication. In addition, the Agency with Choice Medical Assistance fee schedule rates are communicated prior to July 1 each year through a public notice published in the Pennsylvania Bulletin.

ODP determined after public input that a transition period of two (2) years is needed in order to ensure the health and welfare of participants and minimize risk to participants and providers so that providers can adjust to the new PPS. The two-year transition for only cost-based services includes implementation of a revenue reconciliation process from July 1, 2009- June 30, 2011 (revenue reconciliation does not include fee schedule, outcome-based, or participant-directed services). Revenue reconciliation is designed to mitigate significant changes in a provider's total payments resulting solely from the change in the rate-setting methodology (as opposed to significant changes in the number and type of services delivered).

The provider bills throughout the fiscal year using the payment rates ODP established. Final payments to the provider are made in accordance with the revenue reconciliation process. Under the revenue reconciliation process, each provider's total paid claims are compared to the provider's revenue from a prior year for applicable services and additional services provided during the current fiscal year for purposes of determining the final payment to the provider, which is communicated to each provider at intervals throughout the fiscal year.

AEs and providers are subject to the requirements of the federal Single Audit Act. Resolution of these audits is coordinated by the Department's Bureau of Financial Operations (BFO). BFO and the Pennsylvania Comptroller's Office also conduct special audits of providers and AEs, upon request from ODP. BFO is involved with financial reporting, financial policy, and audit policy of ODP. The audits are supplemented by cost report desk reviews and audits. ODP uses standard procedures for the desk review of all cost reports, and a sampling methodology for conducting audits of the cost reports.

Claims are processed through PROMISE which is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS). Claims and payments are monitored by ODP and AEs through the use of PROMISE and HCSIS generated reports.

ODP has obtained public comment on the ODP rate determination methods in a variety of formats which include, stakeholder workgroup discussions, draft documents distributed for public comment, communications and public meetings.

- 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:

Effective July 1, 2009, all waiver providers, including cost based and fee schedule providers, vendors, FMS providers and OHCDS providers that sign a provider agreement or contract with ODP bill through the PROMISE system and are paid by the state Treasury. Qualified support service workers and vendors providing services through an FMS for self directing individuals and vendors paid by an Organized Health Care Delivery System provider for non self-directing individuals do not bill directly through the PROMISE system as this is the role and responsibility of the FMS and the OHCDS provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. **Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services**

and certify their State government 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 State government 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 Local Government Agencies.**

Specify: (a) the local government 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 through the PROMISe system. 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. 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 §92.42.

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:

- 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 makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. 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 State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government 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 State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and 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 State or local government providers is the same as the amount paid to private**

providers of the same service.

- The amount paid to State or local government 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 State or local government providers differs from the amount paid to private providers of the same service. When a State or local government 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:

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 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:

Agencies that are qualified as a waiver provider, and render at least one direct waiver service may function as an Organized Health Care Delivery System (OHCDS). Providers that function as an OHCDS may subcontract with individuals or entities that have been designated as vendor services, if the vendor does not wish to enter into a direct relationship with ODP. Entities that function as an OHCDS for vendor services are responsible to ensure that subcontracted entities meet all applicable provider qualification standards for the service they are rendering. In the event of subcontracting arrangements, the OHCDS must comply with ODP's Subcontracting Arrangements policies.

OHCDS providers must meet the following criteria:

- Enroll in PROMISE as a provider of P/FDS Waiver services;
- Enter service offering(s) in HCSIS;
- Successfully complete the Provider Qualifications module in HCSIS for at least one waiver service and ensure the requirements of Appendix C, including provider qualification standards, are met;
- Enter into a Provider Agreement for Participation in Pennsylvania's P/FDS Waiver with ODP;
- Utilize the rate that is charged to the general public, dependent on the waiver service provided. See the last paragraph of this section for additional requirements related to payment for vendor services;
- Render at least one P/FDS Waiver service;
- Cooperate with provider monitoring conducted by ODP or one of its designees, and ensure the vendor cooperates with such monitoring;
- Cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring and
- Maintain documentation on service delivery.

Participants are provided with information on willing and qualified providers, as outlined in Appendix D-1-f. This information includes the providers identified in the ODP Services and Support Directory (SSD) for services needed by the participant. The SSD includes both providers that function as an OHCDS and those that do not. The participant is free to choose among the willing and qualified providers, despite their designation as an OHCDS. The SSD does not differentiate between providers functioning as an OHCDS and those that do not.

AEs are required to complete provider monitoring of all Waiver providers in accordance with this Waiver and as per ODP policies and procedures. The monitoring is required to be conducted to ensure ongoing compliance with the providers outlined in the current ODP/Provider Agreement, applicable licensing requirements, and written policies and procedures. The monitoring must include a review of compliance with applicable provider qualification standards for all services for which the provider is enrolled and qualified to render.

The AE Operating Agreement requires AEs, as part of provider monitoring, to review OHCDS contracts with vendors to ensure they meet applicable state and federal requirements.

The cost of the vendor good or service must be the same cost charged to the general (or self-paying) public. The cost of the good must be verified by the AE. Prior to authorizing the service, the AE will verify that the vendor rate does not exceed the rate charged to the general public.

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 State 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 State 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 State 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 Government 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 local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government 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 local government 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) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *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:

- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

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.

ODP requires providers to utilize ODP's rate setting methodology in the determination of rates for waiver services. This includes the use of a standardized cost report and instructions, developed by ODP, that establishes rates for residential waiver services. The cost report calculates both waiver eligible and ineligible costs for residential services. The cost report 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 cost report. Completion of the cost report results in an eligible rate and an ineligible rate.

Providers complete cost reports 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.

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:

	<input type="button" value="▲"/> <input type="button" value="▼"/>
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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	13193.45	10275.00	23468.45	135888.00	5920.00	141808.00	118339.55
2	13367.20	10480.00	23847.20	138605.00	6039.00	144644.00	120796.80
3	15931.11	10690.00	26621.11	141378.00	6160.00	147538.00	120916.89
4	16533.61	10904.00	27437.61	144205.00	6283.00	150488.00	123050.39
5	16621.25	11122.00	27743.25	147089.00	6409.00	153498.00	125754.75

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	10739	10739
Year 2	12045	12045
Year 3	12045	12045
Year 4	12045	12045
Year 5	12045	12045

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- 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 300 days.

Estimates were derived from the extrapolation of PROMISE claims data.

Service definitions were 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.

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
Education Support Services
Home and Community Habilitation
Homemaker/Chore
Licensed Day Habilitation
Prevocational Services
Respite
Supported Employment - Job Finding and Job Support
Supports Coordination
Unlicensed Residential Habilitation
Nursing Services
Therapy Services
Supports Broker Services
Assistive Technology
Behavioral Support
Companion
Home Accessibility Adaptations
Home Finding
Specialized Supplies
Transitional Work Services
Transportation
Vehicle Accessibility Adaptations

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
Education Support Services Total:						0.00
Education Support Services	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation Total:						40194000.00
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 3	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	4620	1740.00	5.00	40194000.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Homemaker/Chore Total:						1175740.72
Homemaker/Chore	Hour	434	94.00	28.82	1175740.72	
Licensed Day Habilitation Total:						1109928.00
Level 3 Enhanced (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 2 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 4 (CH 2380)	N/A	0	0.00	0.01	0.00	
Basic Staff Support (CH 2380)	N/A	0	0.00	0.01	0.00	
Licensed Day Habilitation	Quarter Hour	103	2400.00	4.49	1109928.00	
Level 1 (CH 2380)	N/A	0	0.00	0.01	0.00	
Older Adult Day	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Prevocational Services Total:						31680792.00
Level 3	N/A	0	0.00	0.01	0.00	
Prevocational Services	Quarter Hour	6435	2720.00	1.81	31680792.00	
Level 2	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Respite Total:						9819761.28
15-Minute Respite - Level 2	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 2	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3	N/A	0	0.00	0.01	0.00	

Overnight Respite	Day	756	12.00	248.89	2257930.08	
15-Minute Respite - Level 1	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 - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 1	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
Temporary Respite	Quarter Hour	2739	560.00	4.93	7561831.20	
15-Minute Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3	N/A	0	0.00	0.01	0.00	
Supported Employment - Job Finding and Job Support Total:						2680024.16
Supported Employment	Quarter Hour	958	242.00	11.56	2680024.16	
Job Support	N/A	0	0.00	0.01	0.00	
Job Finding	N/A	0	0.00	0.01	0.00	
Supports Coordination Total:						14415389.26
Supports Coordination	Quarter Hour	10739	82.00	16.37	14415389.26	
Unlicensed Residential Habilitation Total:						13652800.00
Unlicensed Family Living Homes	N/A	0	0.00	0.01	0.00	
Unlicensed Residential	1/2 Month	371	23.00	1600.00	13652800.00	
Unlicensed Community Homes	N/A	0	0.00	0.01	0.00	
Nursing Services Total:						5468248.08
Nursing Services	Quarter Hour	172	3123.00	10.18	5468248.08	
Therapy Services Total:						1848837.38
Physical Therapy	Quarter Hour	307	103.00	15.50	490125.50	
Behavior Therapy	Quarter Hour	1533	39.00	18.14	1084536.18	
Occupational Therapy	Quarter Hour	270	10.00	16.42	44334.00	
Visual/Mobility Therapy	Quarter Hour	25	489.00	15.00	183375.00	
Speech/Language Therapy	Quarter Hour	49	58.00	16.35	46466.70	
Supports Broker Services Total:						3685184.00
Supports Broker Services	Quarter Hour	811	640.00	7.10	3685184.00	
Assistive Technology Total:						1153161.45

Assistive Technology	Year	423	1.00	2726.15	1153161.45	
Behavioral Support Total:						0.00
Behavioral Support	N/A	0	0.00	0.01	0.00	
Companion Total:						0.00
Level 1	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:						1198540.63
Home Accessibility Adaptations	Year	259	1.00	4627.57	1198540.63	
Home Finding Total:						0.00
Home Finding	N/A	0	0.00	0.01	0.00	
Specialized Supplies Total:						0.00
Specialized Supplies	N/A	0	0.00	0.01	0.00	
Transitional Work Services Total:						2433828.60
Level 1	N/A	0	0.00	0.01	0.00	
Transitional Work Services	Quarter Hour	938	465.00	5.58	2433828.60	
Level 3	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Transportation Total:						11168209.56
Transportation (Trip)	Trip	3734	376.00	7.90	11091473.60	
Transportation (Mile)	Mile	188	833.00	0.49	76735.96	
Transportation (Per Diem)	N/A	0	0.00	0.01	0.00	
Public Transportation	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	
GRAND TOTAL:					141684445.12	
Total Estimated Unduplicated Participants:					10739	
Factor D (Divide total by number of participants):					13193.45	
Average Length of Stay on the Waiver:						300

Appendix J: Cost Neutrality Demonstration

5. ESTIMATION OF EXPENSES (0.01)

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
Education Support Services Total:						0.00
Education Support Services	N/A	0	0.00	0.01	0.00	
Home and Community Habilitation Total:						45833740.80
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Level 3	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	4604	1952.00	5.10	45833740.80	
Level 2	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Homemaker/Chore Total:						1381212.00
Homemaker/Chore	Hour	435	108.00	29.40	1381212.00	
Licensed Day Habilitation Total:						1299391.80
Level 3 Enhanced (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 2 (CH 2380)	N/A	0	0.00	0.01	0.00	
Level 4 (CH 2380)	N/A	0	0.00	0.01	0.00	
Basic Staff Support (CH 2380)	N/A	0	0.00	0.01	0.00	
Licensed Day Habilitation	Quarter Hour	105	2702.00	4.58	1299391.80	
Level 1 (CH 2380)	N/A	0	0.00	0.01	0.00	
Older Adult Day	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced (CH 2380)	N/A	0	0.00	0.01	0.00	
Prevocational Services Total:						35093251.25

Level 3	N/A	0	0.00	0.01	0.00	
Prevocational Services	Quarter Hour	6275	3023.00	1.85	35093251.25	
Level 2	N/A	0	0.00	0.01	0.00	
Level 4	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 4 Enhanced	N/A	0	0.00	0.01	0.00	
Level 1	N/A	0	0.00	0.01	0.00	
Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
Respite Total:						11527885.01
15-Minute Respite - Level 2	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 2	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3	N/A	0	0.00	0.01	0.00	
Overnight Respite	Day	870	12.00	253.87	2650402.80	
15-Minute Respite - Level 1	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 - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 3 Enhanced	N/A	0	0.00	0.01	0.00	
24-Hour Respite - Level 1	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 2 Enhanced	N/A	0	0.00	0.01	0.00	
Temporary Respite	Quarter Hour	2797	631.00	5.03	8877482.21	
15-Minute Respite - Basic Staff Support	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 3	N/A	0	0.00	0.01	0.00	
Supported Employment - Job Finding and Job Support Total:						3152928.96
Supported Employment	Quarter Hour	976	274.00	11.79	3152928.96	
Job Support	N/A	0	0.00	0.01	0.00	
Job Finding	N/A	0	0.00	0.01	0.00	
Supports Coordination Total:						16494423.00
Supports Coordination	Quarter Hour	12045	82.00	16.70	16494423.00	
Unlicensed Residential Habilitation Total:						14563968.00
Unlicensed Family Living Homes	N/A	0	0.00	0.01	0.00	

Unlicensed Residential	1/2 Month	388	23.00	1632.00	14563968.00	
Unlicensed Community Homes	N/A	0	0.00	0.01	0.00	
Nursing Services Total:						6464881.98
Nursing Services	Quarter Hour	181	3441.00	10.38	6464881.98	
Therapy Services Total:						2135603.90
Physical Therapy	Quarter Hour	324	103.00	15.81	527611.32	
Behavior Therapy	Quarter Hour	1616	44.00	18.50	1315424.00	
Occupational Therapy	Quarter Hour	285	10.00	16.75	47737.50	
Visual/Mobility Therapy	Quarter Hour	26	489.00	15.30	194524.20	
Speech/Language Therapy	Quarter Hour	52	58.00	16.68	50306.88	
Supports Broker Services Total:						4327927.20
Supports Broker Services	Quarter Hour	820	729.00	7.24	4327927.20	
Assistive Technology Total:						1354186.29
Assistive Technology	Year	487	1.00	2780.67	1354186.29	
Behavioral Support Total:						0.00
Behavioral Support	N/A	0	0.00	0.01	0.00	
Companion Total:						0.00
Level 1	N/A	0	0.00	0.01	0.00	
Level 3	N/A	0	0.00	0.01	0.00	
Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:						1406595.76
Home Accessibility Adaptations	Year	298	1.00	4720.12	1406595.76	
Home Finding Total:						0.00
Home Finding	N/A	0	0.00	0.01	0.00	
Specialized Supplies Total:						0.00
Specialized Supplies	N/A	0	0.00	0.01	0.00	
Transitional Work Services Total:						2858371.50
Level 1	N/A	0	0.00	0.01	0.00	
Transitional Work Services	Quarter Hour	985	510.00	5.69	2858371.50	
Level 3	N/A	0	0.00	0.01	0.00	

Basic Staff Support	N/A	0	0.00	0.01	0.00	
Level 2	N/A	0	0.00	0.01	0.00	
Transportation Total:						13113499.40
Transportation (Trip)	Trip	4092	395.00	8.06	13027700.40	
Transportation (Mile)	Mile	206	833.00	0.50	85799.00	
Transportation (Per Diem)	N/A	0	0.00	0.01	0.00	
Public Transportation	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	
GRAND TOTAL:					161007866.85	
Total Estimated Unduplicated Participants:					12045	
Factor D (Divide total by number of participants):					13367.20	
Average Length of Stay on the Waiver:					300	

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
Education Support Services Total:						126676.80
Education Support Services	Year	40	1.00	3166.92	126676.80	
Home and Community Habilitation Total:						58874225.80
Level 3 Enhanced	Quarter Hour	230	1350.00	7.61	2362905.00	
Level 3	Quarter Hour	2446	2430.00	6.46	38396818.80	
Level 4 Enhanced	Quarter Hour	50	1282.00	15.22	975602.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	400	2250.00	6.45	5805000.00	
Level 4	Quarter Hour	100	1880.00	9.19	1727720.00	
Level 1	Quarter Hour	500	2300.00	3.95	4542500.00	
Basic Staff Support					5063680.00	

	Quarter Hour	688	2300.00	3.20		
Homemaker/Chore Total:						361050.00
Homemaker/Chore	Hour	435	40.00	20.75	361050.00	
Licensed Day Habilitation Total:						19710988.22
Level 3 Enhanced (CH 2380)	Quarter Hour	9	2502.00	9.07	204238.26	
Level 3 (CH 2380)	Quarter Hour	9	2802.00	8.07	203509.26	
Level 2 (CH 2380)	Quarter Hour	500	2802.00	3.00	4203000.00	
Level 4 (CH 2380)	Quarter Hour	9	2802.00	12.82	323294.76	
Basic Staff Support (CH 2380)	Quarter Hour	1200	2902.00	2.45	8531880.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Level 1 (CH 2380)	Quarter Hour	600	2902.00	2.80	4875360.00	
Older Adult Day	Quarter Hour	100	2702.00	4.00	1080800.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	9	2502.00	12.83	288905.94	
Prevocational Services Total:						53139177.63
Level 3	Quarter Hour	122	3273.00	1.89	754688.34	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	448	3273.00	1.88	2756651.52	
Level 4	Quarter Hour	122	2973.00	2.00	725412.00	
Basic Staff Support	Quarter Hour	5225	4000.00	1.80	37620000.00	
Level 4 Enhanced	Quarter Hour	108	2943.00	2.08	661115.52	
Level 1	Quarter Hour	1509	3573.00	1.85	9974565.45	
Level 3 Enhanced	Quarter Hour	104	3273.00	1.90	646744.80	
Respite Total:						6357445.04
15-Minute Respite - Level 2	Quarter Hour	524	670.00	3.16	1109412.80	
24-Hour Respite - Basic Staff Support	Day	50	18.00	230.00	207000.00	
24-Hour Respite - Level 2	Day	250	18.00	202.44	910980.00	
24-Hour Respite - Level 3	Day	86	10.00	404.89	348205.40	
Overnight Respite	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 1	Quarter Hour	200	613.00	3.00	367800.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	100	630.00	13.57	854910.00	
24-Hour Respite - Level 2 Enhanced	Day	58	12.00	434.26	302244.96	

24-Hour Respite - Level 3 Enhanced	Day	58	12.00	868.53	604496.88	
24-Hour Respite - Level 1	Day	244	12.00	235.00	688080.00	
15-Minute Respite - Level 2 Enhanced	Quarter Hour	100	630.00	6.79	427770.00	
Temporary Respite	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Basic Staff Support	Quarter Hour	200	613.00	2.75	337150.00	
15-Minute Respite - Level 3	Quarter Hour	50	630.00	6.33	199395.00	
Supported Employment - Job Finding and Job Support Total:						3155064.00
Supported Employment	N/A	0	0.00	0.01	0.00	
Job Support	Quarter Hour	600	374.00	7.03	1577532.00	
Job Finding	Quarter Hour	600	374.00	7.03	1577532.00	
Supports Coordination Total:						16820360.70
Supports Coordination	Quarter Hour	12045	82.00	17.03	16820360.70	
Unlicensed Residential Habilitation Total:						3635200.00
Unlicensed Family Living Homes	Day	40	320.00	122.00	1561600.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Unlicensed Community Homes	Day	40	320.00	162.00	2073600.00	
Nursing Services Total:						745536.00
Nursing Services	Quarter Hour	176	400.00	10.59	745536.00	
Therapy Services Total:						1691897.06
Physical Therapy	Quarter Hour	324	103.00	14.19	473548.68	
Behavior Therapy	Quarter Hour	1616	44.00	13.00	924352.00	
Occupational Therapy	Quarter Hour	285	10.00	15.54	44289.00	
Visual/Mobility Therapy	Quarter Hour	26	489.00	15.61	198465.54	
Speech/Language Therapy	Quarter Hour	52	58.00	16.99	51241.84	
Supports Broker Services Total:						434682.00
Supports Broker Services	Quarter Hour	100	779.00	5.58	434682.00	
Assistive Technology Total:						1381268.36
Assistive Technology	Year	487	1.00	2836.28	1381268.36	
Behavioral Support Total:						521280.00
Behavioral Support	Quarter Hour	500	64.00	16.29	521280.00	
Companion Total:						1424720.00

Level 1	Quarter Hour	60	1100.00	0.90	59400.00	
Level 3	Quarter Hour	250	1100.00	4.26	1171500.00	
Basic Staff Support	Quarter Hour	60	1100.00	0.72	47520.00	
Level 2	Quarter Hour	70	1100.00	1.90	146300.00	
Home Accessibility Adaptations Total:						1194000.96
Home Accessibility Adaptations	Year	248	1.00	4814.52	1194000.96	
Home Finding Total:						72560.00
Home Finding	Quarter Hour	40	200.00	9.07	72560.00	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Transitional Work Services Total:						4507926.40
Level 1	Quarter Hour	358	650.00	5.50	1279850.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Level 3	Quarter Hour	52	310.00	7.97	128476.40	
Basic Staff Support	Quarter Hour	600	630.00	4.20	1587600.00	
Level 2	Quarter Hour	600	450.00	5.60	1512000.00	
Transportation Total:						17239166.96
Transportation (Trip)	Trip	4032	395.00	10.15	16165296.00	
Transportation (Mile)	Mile	206	833.00	0.52	89230.96	
Transportation (Per Diem)	Day	150	120.00	27.00	486000.00	
Public Transportation	Outcome Based	1000	92.00	5.42	498640.00	
Vehicle Accessibility Adaptations Total:						372000.00
Vehicle Accessibility Adaptations	Year	62	1.00	6000.00	372000.00	
GRAND TOTAL:					191890225.93	
Total Estimated Unduplicated Participants:					12045	
Factor D (Divide total by number of participants):					15931.11	
Average Length of Stay on the Waiver:						300

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						129210.40
Education Support Services	Year	40	1.00	3230.26	129210.40	
Home and Community Habilitation Total:						63540800.12
Level 3 Enhanced	Quarter Hour	230	1300.00	7.53	2251470.00	
Level 3	Quarter Hour	2522	2494.00	6.59	41450230.12	
Level 4 Enhanced	Quarter Hour	50	1200.00	15.06	903600.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	400	2500.00	6.58	6580000.00	
Level 4	Quarter Hour	100	1880.00	9.10	1710800.00	
Level 1	Quarter Hour	500	2500.00	4.03	5037500.00	
Basic Staff Support	Quarter Hour	688	2500.00	3.26	5607200.00	
Homemaker/Chore Total:						357222.00
Homemaker/Chore	Hour	435	40.00	20.53	357222.00	
Licensed Day Habilitation Total:						19692658.22
Level 3 Enhanced (CH 2380)	Quarter Hour	9	2502.00	9.07	204238.26	
Level 3 (CH 2380)	Quarter Hour	9	2802.00	8.07	203509.26	
Level 2 (CH 2380)	Quarter Hour	500	2802.00	3.06	4287060.00	
Level 4 (CH 2380)	Quarter Hour	9	2802.00	12.82	323294.76	
Basic Staff Support (CH 2380)	Quarter Hour	1200	2902.00	2.50	8706000.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Level 1 (CH 2380)	Quarter Hour	600	2902.00	2.86	4979832.00	
Older Adult Day	Quarter Hour	100	2702.00	2.59	699818.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	9	2502.00	12.83	288905.94	
Prevocational Services Total:						54379905.99
Level 3	Quarter Hour	122	3273.00	1.93	770660.58	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	448	3273.00	1.92	2815303.68	
Level 4	Quarter Hour	122	2973.00	2.04	739920.24	

Basic Staff Support	Quarter Hour	5235	4000.00	1.84	38529600.00	
Level 4 Enhanced	Quarter Hour	108	2943.00	2.12	673829.28	
Level 1	Quarter Hour	1509	3573.00	1.89	10190231.73	
Level 3 Enhanced	Quarter Hour	104	3273.00	1.94	660360.48	
Respite Total:						6225577.04
15-Minute Respite - Level 2	Quarter Hour	524	670.00	3.13	1098880.40	
24-Hour Respite - Basic Staff Support	Day	50	18.00	234.60	211140.00	
24-Hour Respite - Level 2	Day	250	18.00	200.36	901620.00	
24-Hour Respite - Level 3	Day	86	10.00	400.72	344619.20	
Overnight Respite	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 1	Quarter Hour	200	613.00	3.06	375156.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	100	630.00	13.43	846090.00	
24-Hour Respite - Level 2 Enhanced	Day	58	12.00	429.80	299140.80	
24-Hour Respite - Level 3 Enhanced	Day	58	12.00	859.59	598274.64	
24-Hour Respite - Level 1	Day	244	12.00	200.00	585600.00	
15-Minute Respite - Level 2 Enhanced	Quarter Hour	100	630.00	6.72	423360.00	
Temporary Respite	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Basic Staff Support	Quarter Hour	200	613.00	2.81	344506.00	
15-Minute Respite - Level 3	Quarter Hour	50	630.00	6.26	197190.00	
Supported Employment - Job Finding and Job Support Total:						3217896.00
Supported Employment	N/A	0	0.00	0.01	0.00	
Job Support	Quarter Hour	600	374.00	7.17	1608948.00	
Job Finding	Quarter Hour	600	374.00	7.17	1608948.00	
Supports Coordination Total:						17156175.30
Supports Coordination	Quarter Hour	12045	82.00	17.37	17156175.30	
Unlicensed Residential Habilitation Total:						3707904.00
Unlicensed Family Living Homes	Day	40	320.00	124.44	1592832.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Unlicensed Community Homes	Day	40	320.00	165.24	2115072.00	
Nursing Services Total:						760320.00
Nursing Services	Quarter Hour	176	400.00	10.80	760320.00	

Therapy Services Total:						2033312.38
Physical Therapy	Quarter Hour	324	103.00	18.14	605368.08	
Behavior Therapy	Quarter Hour	1616	44.00	15.00	1066560.00	
Occupational Therapy	Quarter Hour	285	10.00	19.12	54492.00	
Visual/Mobility Therapy	Quarter Hour	26	489.00	19.51	248050.14	
Speech/Language Therapy	Quarter Hour	52	58.00	19.51	58842.16	
Supports Broker Services Total:						759525.00
Supports Broker Services	Quarter Hour	100	779.00	9.75	759525.00	
Assistive Technology Total:						1408895.87
Assistive Technology	Year	487	1.00	2893.01	1408895.87	
Behavioral Support Total:						618240.00
Behavioral Support	Quarter Hour	500	64.00	19.32	618240.00	
Companion Total:						1397000.00
Level 1	Quarter Hour	60	1100.00	0.88	58080.00	
Level 3	Quarter Hour	250	1100.00	4.18	1149500.00	
Basic Staff Support	Quarter Hour	60	1100.00	0.70	46200.00	
Level 2	Quarter Hour	70	1100.00	1.86	143220.00	
Home Accessibility Adaptations Total:						1217880.88
Home Accessibility Adaptations	Year	248	1.00	4910.81	1217880.88	
Home Finding Total:						0.00
Home Finding	N/A	0	0.00	0.01	0.00	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Transitional Work Services Total:						4596042.60
Level 1	Quarter Hour	358	650.00	5.61	1305447.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Level 3	Quarter Hour	52	310.00	8.13	131055.60	
Basic Staff Support	Quarter Hour	600	630.00	4.28	1617840.00	
Level 2	Quarter Hour	600	450.00	5.71	1541700.00	
Transportation Total:						17456603.44
Transportation (Trip)	Trip	4002	395.00	10.35	16361176.50	

Transportation (Mile)	Mile	206	833.00	0.53	90946.94	
Transportation (Per Diem)	Day	150	120.00	27.54	495720.00	
Public Transportation	Outcome Based	1000	92.00	5.53	508760.00	
Vehicle Accessibility Adaptations Total:						367200.00
Vehicle Accessibility Adaptations	Year	60	1.00	6120.00	367200.00	
GRAND TOTAL:					199147369.24	
Total Estimated Unduplicated Participants:					12045	
Factor D (Divide total by number of participants):					16533.61	
Average Length of Stay on the Waiver:					300	

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						131794.80
Education Support Services	Year	40	1.00	3294.87	131794.80	
Home and Community Habilitation Total:						61227885.00
Level 3 Enhanced	Quarter Hour	230	1300.00	7.68	2296320.00	
Level 3	Quarter Hour	2424	2500.00	6.72	40723200.00	
Level 4 Enhanced	Quarter Hour	50	1200.00	15.36	921600.00	
Home and Community Habilitation	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	335	2500.00	6.71	5619625.00	
Level 4	Quarter Hour	100	1880.00	9.28	1744640.00	
Level 1	Quarter Hour	435	2500.00	4.11	4469625.00	
Basic Staff Support	Quarter Hour	655	2500.00	3.33	5452875.00	
Homemaker/Chore Total:						364356.00
Homemaker/Chore	Hour	435	40.00	20.94	364356.00	
Licensed Day Habilitation Total:						20089319.70
Level 3 Enhanced (CH)					208291.50	

2380)	Quarter Hour	9	2502.00	9.25		
Level 3 (CH 2380)	Quarter Hour	9	2802.00	8.23	207544.14	
Level 2 (CH 2380)	Quarter Hour	500	2802.00	3.12	4371120.00	
Level 4 (CH 2380)	Quarter Hour	9	2802.00	13.08	329851.44	
Basic Staff Support (CH 2380)	Quarter Hour	1200	2902.00	2.55	8880120.00	
Licensed Day Habilitation	N/A	0	0.00	0.01	0.00	
Level 1 (CH 2380)	Quarter Hour	600	2902.00	2.92	5084304.00	
Older Adult Day	Quarter Hour	100	2702.00	2.64	713328.00	
Level 4 Enhanced (CH 2380)	Quarter Hour	9	2502.00	13.09	294760.62	
Prevocational Services Total:						56112634.35
Level 3	Quarter Hour	122	3273.00	1.97	786632.82	
Prevocational Services	N/A	0	0.00	0.01	0.00	
Level 2	Quarter Hour	448	3273.00	1.96	2873955.84	
Level 4	Quarter Hour	122	2973.00	2.08	754428.48	
Basic Staff Support	Quarter Hour	5310	4000.00	1.88	39931200.00	
Level 4 Enhanced	Quarter Hour	108	2943.00	2.16	686543.04	
Level 1	Quarter Hour	1509	3573.00	1.93	10405898.01	
Level 3 Enhanced	Quarter Hour	104	3273.00	1.98	673976.16	
Respite Total:						6349465.28
15-Minute Respite - Level 2	Quarter Hour	524	670.00	3.19	1119945.20	
24-Hour Respite - Basic Staff Support	Day	50	18.00	239.29	215361.00	
24-Hour Respite - Level 2	Day	250	18.00	204.37	919665.00	
24-Hour Respite - Level 3	Day	86	10.00	408.73	351507.80	
Overnight Respite	N/A	0	0.00	0.01	0.00	
15-Minute Respite - Level 1	Quarter Hour	200	613.00	3.12	382512.00	
15-Minute Respite - Level 3 Enhanced	Quarter Hour	100	630.00	13.70	863100.00	
24-Hour Respite - Level 2 Enhanced	Day	58	12.00	438.40	305126.40	
24-Hour Respite - Level 3 Enhanced	Day	58	12.00	876.78	610238.88	
24-Hour Respite - Level 1	Day	244	12.00	204.00	597312.00	
15-Minute Respite - Level 2 Enhanced	Quarter Hour	100	630.00	6.85	431550.00	
Temporary Respite	N/A	0	0.00	0.01	0.00	

15-Minute Respite - Basic Staff Support	Quarter Hour	200	613.00	2.87	351862.00	
15-Minute Respite - Level 3	Quarter Hour	50	630.00	6.39	201285.00	
Supported Employment - Job Finding and Job Support Total:						3280728.00
Supported Employment	N/A	0	0.00	0.01	0.00	
Job Support	Quarter Hour	600	374.00	7.31	1640364.00	
Job Finding	Quarter Hour	600	374.00	7.31	1640364.00	
Supports Coordination Total:						17501866.80
Supports Coordination	Quarter Hour	12045	82.00	17.72	17501866.80	
Unlicensed Residential Habilitation Total:						3782016.00
Unlicensed Family Living Homes	Day	40	320.00	126.93	1624704.00	
Unlicensed Residential	N/A	0	0.00	0.01	0.00	
Unlicensed Community Homes	Day	40	320.00	168.54	2157312.00	
Nursing Services Total:						775808.00
Nursing Services	Quarter Hour	176	400.00	11.02	775808.00	
Therapy Services Total:						2073875.20
Physical Therapy	Quarter Hour	324	103.00	18.50	617382.00	
Behavior Therapy	Quarter Hour	1616	44.00	15.30	1087891.20	
Occupational Therapy	Quarter Hour	285	10.00	19.50	55575.00	
Visual/Mobility Therapy	Quarter Hour	26	489.00	19.90	253008.60	
Speech/Language Therapy	Quarter Hour	52	58.00	19.90	60018.40	
Supports Broker Services Total:						775105.00
Supports Broker Services	Quarter Hour	100	779.00	9.95	775105.00	
Assistive Technology Total:						1437073.69
Assistive Technology	Year	487	1.00	2950.87	1437073.69	
Behavioral Support Total:						630720.00
Behavioral Support	Quarter Hour	500	64.00	19.71	630720.00	
Companion Total:						1424060.00
Level 1	Quarter Hour	60	1100.00	0.90	59400.00	
Level 3	Quarter Hour	250	1100.00	4.26	1171500.00	
Basic Staff Support	Quarter Hour	60	1100.00	0.71	46860.00	
Level 2	Quarter Hour	70	1100.00	1.90	146300.00	

Home Accessibility Adaptations Total:						1242239.44
Home Accessibility Adaptations	Year	248	1.00	5009.03	1242239.44	
Home Finding Total:						0.00
Home Finding	N/A	0	0.00	0.01	0.00	
Specialized Supplies Total:						125000.00
Specialized Supplies	Year	250	1.00	500.00	125000.00	
Transitional Work Services Total:						4687938.80
Level 1	Quarter Hour	358	650.00	5.72	1331044.00	
Transitional Work Services	N/A	0	0.00	0.01	0.00	
Level 3	Quarter Hour	52	310.00	8.29	133634.80	
Basic Staff Support	Quarter Hour	600	630.00	4.37	1651860.00	
Level 2	Quarter Hour	600	450.00	5.82	1571400.00	
Transportation Total:						17810305.32
Transportation (Trip)	Trip	4002	395.00	10.56	16693142.40	
Transportation (Mile)	Mile	206	833.00	0.54	92662.92	
Transportation (Per Diem)	Day	150	120.00	28.09	505620.00	
Public Transportation	Outcome Based	1000	92.00	5.64	518880.00	
Vehicle Accessibility Adaptations Total:						380786.40
Vehicle Accessibility Adaptations	Year	61	1.00	6242.40	380786.40	
GRAND TOTAL:						200202977.78
Total Estimated Unduplicated Participants:						12045
Factor D (Divide total by number of participants):						16621.25
Average Length of Stay on the Waiver:						300