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OFFICE OF LONG-TERM LIVING BULLETIN

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SUBJECT

Department of Aging/Office of Long-Term Living Home and Community-Based Services Program Policy Clarifications

BY

Jennifer Burnett, Deputy Secretary
Office of Long-Term Living

Introduction

The Office of Long-Term Living (OLTL) has been working closely with the Centers for Medicare & Medicaid Services (CMS) on several waiver amendments and renewals. The two waiver renewals -- Attendant Care and Aging – are accompanied by detailed work plans and contain changes that provide for the issuance of policy clarifications. The purpose of this bulletin is to provide clarification on a number of policy issues that are necessary to implement the OLTL Waiver changes. The following policy clarifications should assist agencies and providers to act in an efficient and consistent fashion across the Commonwealth.

MA-51/ Physician Certification

An MA-51 is no longer required to gain access to OLTL Home and Community-Based Services programs. In order to gain access to an OLTL HCBS program, a physician need only certify that an individual meets the required level of care. This certification is obtained by use of the simpler physician certification form (see sample at Attachment 1), rather than the MA-51.

Additionally, note that the annual reevaluation (the reapplication/recertification) for all OLTL waivers require neither an MA-51 nor a prescription from the participant's physician.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Office of Long Term-Living
P.O. Box 2675
Harrisburg, PA 17105
(717) 705-3705

Visit the Office of Long-Term Living's Web site at www.dpw.state.pa.us/About/OLTL

Criminal History Background Checks in the Participant Directed Services in OLTL Home and Community- Based Programs

To ensure that all participants make informed choice of service and service delivery, criminal history background checks should be requested and obtained for personal assistance workers and support workers who are employed by a participant or their representatives. Participants (or their representatives) may employ a personal assistance worker even when the background check reveals that the worker has a prior criminal record. The final decision always rests with the participant (or designated representative), not the Service Coordination/ Fiscal/Employer Agent. In cases where a participant chooses to hire a worker despite a record of criminal conviction, the participant/employer assumes the risk of employing the individual and must sign an "Acceptance of Responsibility" form (see sample at Attachment 2).

All participant-employed workers must obtain a background check through the Pennsylvania State Police (PSP). In addition, if the worker has not lived in Pennsylvania for the last two years, the worker must obtain a national criminal background check through the Federal Bureau of Investigation (FBI). Criminal history background checks through the Pennsylvania State Police and the FBI will be obtained at no cost to the participant. Obtaining the criminal history background check and paying PSP/FBI will be the responsibility of the Fiscal/Employer Agent. The Fiscal/Employer Agent is also responsible for obtaining and paying for ChildLine clearance if the worker is providing services in a home with a minor child.

Participants must certify that they thoroughly understand the statements in the "Acceptance of Responsibility" form (e.g., "I understand the statements in this document)." This form may be read to the participant, but, in any event, the person reviewing the form with the participant shall give the participant adequate opportunity to read it before it is signed.

Care Management Instrument (CMI)

The Care Manager completes the CMI in collaboration with the participant (or the participant's representative / others at the participant's request) when an individual applies for the Aging Waiver or the Options program, at the annual reevaluation or as individual service needs change. NOTE: The CMI does not need to be completed every six (6) months unless the participant's needs change.

Services Outside the Home

The ability to drive an automobile does not automatically disqualify a participant from NFCE status or participation in an OLTL Waiver. The purpose of the HCBS waivers is to preserve and encourage full integration and engagement of long-term living participants in their neighborhoods and communities. Requiring older adults or individuals with physical disabilities to forfeit mobility and remain confined to their homes in order to attain or maintain Medicaid eligibility is not required by federal law and defeats the purpose of HCBS.

Mandatory Enrollment in the Aging Waiver

OLTL is clarifying the provision previously contained within Chapter 3 of the HCBS Manual that provided Area Agencies on Aging (AAAs) with discretion to develop a service plan (funded by Options program) not to exceed $200 per month to individuals who decline to participate in the Aging Waiver. The Options program is only available for individuals who do not meet the financial eligibility criteria for a Medicaid program and therefore should not be used to substitute services in the manner previously described in Chapter 3 of the HCBS Manual.

If an individual clearly appears to financially and/or clinically qualify for MA waiver services, the AAA is required to process the enrollment through the County Assistance Office. If an individual is found to be eligible for Aging Waiver services but declines enrollment in the waiver, a service plan cannot be funded by the Options program. The individual cannot qualify for services under Options, Family Caregiver Support or other state-funded HCBS programs.

Choice of Services

This clarification replaces the requirement within Chapter II of the Attendant Care Program Requirements mandating providers to offer all of the services available through the Attendant Care Program. Providers of OLTL HCBS programs are permitted to choose which services they will provide among the menu of services available in the program -- they are not required to provide all of the services.

Choice of Providers

Individuals receiving HCBS through the OLTL benefit from "choice of providers," *i.e.,* participants have the ability to choose from a list of qualified providers for all services that have been authorized in their service plan, regardless of service model. It is the responsibility of the enrolling and the service coordination agencies to provide participants with a list of <u>all</u> qualified providers who are enrolled in the program at the time of the participant's enrollment and on a periodic basis thereafter. Participants in HCBS through the OLTL are not required – nor can they be compelled -- to use a specific provider or to use one provider for all services. (See Attachments 4 and 5 regarding provider choice protocol and form)

Personal Emergency Response System (PERS)

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button. The system is connected to the person's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals (1) who live alone or who are alone for significant parts of the day, (2) have no regular caregiver for extended periods of time, and (3) who would otherwise require extensive routine supervision. Installation and maintenance of the PERS are included in this service.

Participants are assessed for services, frequency and duration based upon needs identified and documented in their service plan.

One time installation of the PERS unit is covered under the W1718 procedure code. Repairs, maintenance and replacement are covered under the W1722 procedure code.

Telephony Services

The OLTL will accept telephony time and attendance system electronic records in place of participant-signed timesheets. The OLTL requires that acceptable telephony systems:

- Have the capability to schedule and modify worker hours and services
- Allow a start time window (allow call-in within 5-15 minutes of scheduled time)
- Allow an end time window (allow call-out within 5-15 minutes of scheduled time)
- Provide real time notice of delayed service visits and missed visits
- Use participant telephone number (provide justification if other than the land line)
- Not be the phone of a paid staff worker
- Use a toll-free number for calling in
- Generate bills using data recorded from the telephony system
- Are secure and HIPAA compliant
- Are voluntary for participants

Agencies must have a protocol in place for making edits to electronic time sheets that includes making contact with the participant and the worker.

Service Providers who may use telephony systems are as follows:

- Home Health Agency
- Home Care Agency
- Licensed Dietician
- Out-Patient Rehabilitation Agency/Behavioral Therapy Provider
- Service Coordination Agencies
- Visiting Nurses

This clarification pertains to the following Services provided under OLTL HCBS programs:

- Personal Assistance Services
- Home Health
- Respite
- Therapeutic and Counseling Services
- Community Integration
- Service Coordination
- Participant-Directed Community Supports
- Participant-Directed Goods and Services

Provider Certification

Home and community-based waiver participants must be allowed to obtain services from any willing and qualified provider of a service who is enrolled as a Medical Assistance provider. A qualified waiver provider means an individual or entity that meets the qualifications that are specified in the waiver program for the service that the provider renders.

AAAs and Service Coordination Agencies may not impose additional qualifications or requirements on providers beyond those specified in the terms of the federal waiver approved by CMS. Examples of requirements that are not permitted under the terms of the federal waivers: provision of surety bonds by providers wishing to participate in Medical Assistance or demonstration that the provider maintains a business office within county limits. Additionally, AAAs or Service Coordination Agencies may not limit the number of qualified providers enrolled in an OLTL Waiver.

Community Transition Services

Community Transition Services are one-time expenses for individuals who make the transition from an institution to their own home, apartment or family/friend living arrangement.

Funds may be used to pay necessary expenses for an individual to establish his/her basic living arrangement and move into that arrangement such as: security deposits that are required to obtain a lease on an apartment or house and specific set-up fees or deposits (utilities, telephone, electric and gas heating) and essential furnishings to establish basic living arrangements (bed, dining table and chairs, eating utensils and food preparation items).

Community Transition Services <u>do not include</u> monthly rental or mortgage expense; food, regular utility charges; and/or household appliances that are intended for purely diversional/recreational purposes. Under no circumstances will these services be used to pay for furnishings or set up living arrangements that are owned or leased by a waiver provider.

Community Transition Services are needs-based, and furnished only to the extent that (1) they are reasonable and necessary as determined through the service plan development process, and (2) the individual is unable to meet such expense or the service cannot be obtained from other sources. These goods and services must be pre-authorized in the waiver participant's individual support plan.

Hearings and Appeals for Department of Aging/Office of Long-Term Living HCBS

To promote consistency among the HCBS programs and ensure that participants have timely access to a formal administrative hearing as required by Medicaid rules, the Department of Aging/Office of Long-Term Living is eliminating the informal resolution process for appeals brought by participants in the Aging Waiver and the Options program. This clarification serves as notice that the OLTL is waiving its regulations found at 6 Pa. Code Section 3.5 and the informal resolution process as described in Chapter 5 of the HCBS Manual, for Aging Waiver and Options appeals.

AAAs should create and use a separate Notice of Adverse Action form when writing to Aging Waiver and Options program participants. This Notice should instruct participants to request

an appeal by writing to the appropriate staff member at the AAA, rather than to the Secretary of Aging. For these types of appeals, the AAA will now be responsible for recording receipt of the appeal request and forwarding it to DPW's Bureau of Hearings and Appeals (BHA). Instructions on sending formal appeals to BHA and a template cover sheet will be distributed under separate cover.

Note that the Department of Aging will continue to handle other appeals (e.g., OAPSA alleged perpetrator designation, service provider appeals, Domiciliary Care certifications), through the informal resolution procedure outlined in our regulations.

AAAs should continue their attempts to resolve the issue underlying the appeal at the local level; however, this process should not delay the agency's submission of the hearing request to BHA. If attempts to resolve the issue are successful, the participant should notify BHA and request that the hearing be cancelled.

Locus of Care

Effective immediately, AAAs shall not complete questions 10 and 12 under Section 6a in the Level of Care Assessment (LOCA) form. Questions 9 and 11, indicating the participant's preferred service programs, should be used as the major determining factor for the participant's service setting and program.