

# 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Changes in this renewal include:

- Defines OLTL as a division within the Single State Medicaid Agency that operates the waiver, removing references to the dual deputate with Department of Aging.
- Adds the Independent Enrollment Broker to the list of entities identified in Appendix A to which OLTL delegates certain administrative functions.
- Clarifies that intermediate care and skilled nursing are not two distinct levels of care, but historical terms to reflect nursing facility level of care.
- Removes the references to the PA-25 and PA-45 waivers. The PA-67 1915(b) waiver, which expanded mandatory managed care statewide, was effective 1/1/2012.
- Clarifies that providers must have processes for participants with limited English proficiency to access language services.

## 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*):

**HIV/AIDS Waiver**

C. **Type of Request: renewal**

**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.0192**

**Waiver Number: PA.0192.R05.00**

**Draft ID: PA.019.05.00**

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

Regular Waiver

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

01/01/15

### 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:  
Services are provided to individuals that have been certified to need either skilled nursing or intermediate 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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

## 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:

PA67 Waiver effective January 1, 2012 through December 31, 2014.

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 HIV/AIDS Waiver provides personal assistance services, home health aide and nursing services, durable medical equipment and

nutritional counseling to individuals with Symptomatic HIV or AIDS who meet hospital or nursing facility level of care criteria.

The HIV/AIDS Waiver operates as concurrent waiver under 1915(b) and 1915(c) authorities. Mandatory managed care was expanded across the Commonwealth in state fiscal year 2012-2013. Individuals who are not dually eligible for Medicare and Medicaid receive all of their waiver services through Managed Care Organizations. Those waiver participants who are dually eligible for Medicare and Medicaid, receive their services through the 1915(c) waiver.

Case management services for participants served in the managed care counties are provided by the managed care entity itself. Participants that do not participate in managed care entities receive the option of targeted case management from the state plan or from local AIDS Service Organizations.

The Office of Long-Term Living,(OLTL) acting as part of the single State Medicaid Agency (SMA), is responsible for ensuring that the HIV/AIDS Waiver operates in accordance with applicable Federal regulations as well as meeting all 1915 (c) waiver assurances. The SMA maintains oversight of contracted and local/regional entity functions and the development of waiver-related policies and procedures. The State Medicaid Agency (SMA) also ensures that waiver services are provided by qualified enrolled Medicaid providers. The SMA administers HIV/AIDS Waiver services statewide to all participants who meet programmatic eligibility requirements and are Medicaid eligible. OLTL and Office of Medical Assistance Programs, as part of the SMA, approves all administrative functions of the HIV/AIDS Waiver. The SMA has written provider agreements with service providers across the Commonwealth that meet all waiver requirements and are enrolled in Medical Assistance.

The Office of Long- Term Living has submitted a work plan in conjunction with the renewal of this waiver. The work plan addresses planned improvements to the Administrative Authority, Level of Care, Service Planning and Delivery, and Health and Welfare sections of the waiver application which are contained in Appendixes A, B, D and G respectively.

### 3. Components of the Waiver Request

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

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

<input type="radio"/> <b>Yes. This waiver provides participant direction opportunities.</b> <i>Appendix E is required.</i>
<input checked="" type="radio"/> <b>No. This waiver does not provide participant direction opportunities.</b> <i>Appendix E is not required.</i>
- 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

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- 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. Statewideness.** 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:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  - 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,
  - 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:
- Informed of any feasible alternatives under the waiver; and,
  - 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

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*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/IID.
- 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:  
Due to extenuating circumstances, OLTL was unable to obtain public comment on this waiver renewal.
- 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:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

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

## Attachments

### Attachment #1: Transition Plan

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The HIV/AIDS waiver offers the following services: Personal Assistance Services, Specialized Medical Equipment and Supplies, Home Health Aide, Home Health Nursing and Nutritional Consultation services – all designed to support individuals to live more independently in their homes and communities. With the exception of Nutritional Consultation Services which are provided in outpatient clinics, services are provided to participants in their own homes or in the homes of family members or friends. Services are not provided in provider-owned or operated settings.

**ASSESSMENT: Home and Community-Based Settings – Residential Settings**

As stated above, the HIV/AIDS waiver does not offer residential services; all participants receive Personal Assistance Services, which are provided to participants who reside in their own homes or the homes of family members or friends. Personal Assistance Services provide hands-on assistance to participants and are aimed at assisting the participant to complete tasks of daily living that would be performed independently if the individual had no disability. Personal Assistance Services enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

OLTL has determined that all services offered in this waiver comply with the new federal rule.

**Areas in which OLTL is compliant:**

- 42 CFR §441.301 (c) (5) (CMS Prohibited Settings) Home and community-based settings do not include a nursing facility, institution for mental diseases, ICF/ID and hospitals.
- 42 CFR §441.301 (c) (5) (v) In summary, settings that are presumed to have the qualities of an institution include: settings in a publicly or privately owned facility that provides inpatient treatment; settings on the grounds of, or immediately adjacent to, a public institution; and settings that have the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS.
- 42 CFR §441.301 (c) (4) (i) The setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- 42 CFR §441.301 (c) (4) (ii) Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- 42 CFR §441.301 (c) (4) (iii) Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.
- 42 CFR §441.301 (c) (4) (iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- 42 CFR §441.301 (c) (4) (v) – Facilitates choice regarding services and who provides them.
- 42 CFR §441.301 (c) (4) (vi) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- 42 CFR §441.301 (c) (4) (vi) (B) (1) through (3) The individual has privacy in their unit, which includes: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors; individuals sharing units have a choice of roommates in that setting; and individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- 42 CFR §441.301 (c) (4) (vi) (C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- 42 CFR §441.301 (c) (4) (vi) (D) Individuals are able to have visitors of their choosing at any time.
- 42 CFR §441.301 (c) (4) (vi) (E) The setting is physically accessible to the individual.

**TRANSITION PLAN:**

The following actions are being planned for all OLTL waivers:

- OLTL is currently developing a Service Coordinator monitoring tool which will be utilized by SCEs to ensure consistent monitoring of the health and welfare of waiver participants, and to ensure that services are being provided in accordance with the individual service plan. OLTL plans to incorporate questions relating to home and community-based settings as part of this monitoring tool.
- OLTL intends to require providers to conduct a self-assessment of compliance with these provisions of the regulation. In addition, OLTL will be utilizing the QMET monitoring teams to conduct on-site assessments to identify settings that do not comply with the regulation.
- OLTL intends to conduct face-to-face monitoring visits with a sampling of participants in each waiver to assess compliance from the participants' perspective and to ensure participant participation in the process.
- OLTL intends to work with the SCE, provider and QMET to identify where the setting is not in compliance with the regulation, and steps for meeting compliance.
- To ensure OLTL has robust stakeholder input, we will follow our established stakeholder review process to inform the development of any new policies.

#### TIMELINE:

A work plan will be developed to address transition plan items for all OLTL waivers. At least two drafts of the work plan will be shared with stakeholders prior to submission. To summarize these items:

- Development of policy documents, training and/or a service coordination monitoring tool to address person-centered planning weaknesses.
- Development of a Service Coordinator monitoring tool – incorporation of questions relating to home and community-based settings as part of the tool.
- Institution of a broad department-wide assessment of all home and community-based settings to identify any non-compliant outliers.
- Implementation of a provider self-assessment tool, which will both educate them about the new rule and ensure their compliance.
- Utilization of OLTL's QMET monitoring teams to conduct on-site assessments to identify outlier settings that do not comply with the regulation.
- Survey of all Adult Daily Living participants to seek their feedback on the home and community-based environment of the centers they attend.

When provider non-compliance exists or is found and confirmed:

- Develop policies that if followed would ensure that the setting meets the qualities for being home and community-based and does not have the qualities of an institution even if physically located in a setting presumed institutional;
- Work with non-compliant providers as they secure other settings in which to provide their services;
- Work with departmental, other state agencies and licensing entities to potentially make policy and regulatory changes to clearly articulate where waiver Adult Daily Living services can be provided;
- Transition participants to other providers of this service.
- Utilize OLTL's established stakeholder review process to seek input on compliance activities and inform the development of any new policies to ensure OLTL has robust stakeholder input.

### 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.

**Office of Long-Term Living (OLTL)**

(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 Office of Long Term Living (OLTL) operates as a unit within the State Medicaid Agency (SMA) and is responsible for oversight of all aspects of the Aids Waiver.

The Deputy Secretary of the Office of Long -Term Living reports directly to the Secretary of Public Welfare. The Office of Long -Term Living functions as a unit of the Department of Public Welfare. The Secretary of the Department of Public Welfare is the head of the single state Medicaid Agency (SMA). Therefore, the SMA through the Secretary of Public Welfare has ultimate authority over operations of the waiver.

The Secretary of the Department of Public Welfare, the Executive Medicaid Director and the Deputy Secretary of the Office of Long-Term Living meet weekly to discuss operations of the waivers and other long term living programs. In addition, OLTL and staff from the Office of Medical Assistance Programs (OMAP) meet regularly to review and gain consent on Waiver policies, rules and guidelines.

Descriptions of the functions of the operating divisions within the Department, including OLTL and OMAP, are available (through links) on the following Department of Public Welfare website

<http://www.dpw.state.pa.us/dpworganization/index.htm>. The specific roles and responsibilities of these entities in the administration of the waiver are further delineated in waiver policies and procedures.

- 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.**

## 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.:*

OLTL contracts with one non-governmental non-state entity to facilitate eligibility determinations (waiver related enrollment activities), excluding level of care determinations, for multiple home and community-based waivers managed by OLTL, including the HIV/AIDS waiver. Specifically, the Independent Enrollment Broker (IEB) is responsible for the following activities:

- Complete the initial in-home visit and needs assessment;
- Educate individuals on their rights and responsibilities in the waiver program, appeal rights, and the right to choose from any qualified provider;
- Provide applicants with choice of receiving Nursing Facility institutional services, waiver services, or no services and

documenting the applicant's choice on the OLTL Freedom of Choice Form;

- Provide applicants with contact information for their local AIDS Service Organization, a list of qualified Service Coordination agencies and document the individual's choice of Service Coordinator on the OLTL Service Provider Choice Form;
- Assist the applicant to obtain a completed physician certification form from the individual's physician;
- Assist the participant to complete the financial eligibility determination paperwork; and
- Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, and Managed Care Organization as applicable, including sending copies of all completed assessments and forms.

The Managed Care Organizations (MCO) function in accordance with their contract requirements with the Department of Public Welfare for individuals enrolled in the PA 67 1915(b) and Aids 1915(c) Waivers.

The MCO must arrange for and provide the same services to persons with AIDS or symptomatic HIV as those provided under the Department's HIV/AIDS Waiver Program. The MCO must ensure the provision of case management services for persons with AIDS or symptomatic HIV, including access to needed medical and social services using the existing case management program standards of practice followed by the Department or comparable standards approved by the Department.

Administration and oversight of these contracts falls within the purview of OLTL and OMAP.

- 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:*

- 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:*

## 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:

The State Medicaid Agency's Bureau of Managed Care Operations under the Division of Quality and Special Needs Coordination is responsible for the oversight of MCOs in with regards to HIV/AIDS services. The BMCO has a database that contains the contract requirements broken down into standard numbers. These standards are then assigned to various division areas within BMCO. The standard for review of the HIV/AIDS CMS requirement is assigned as S/D 61.1 and is assigned to the Special Needs area for response.

## 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: The State Medicaid Agency monitors the Managed Care Organizations for operations of the Aids 1915 (b) Waiver using the MCO Component Quality Monitoring Plan Matrix detailed in Section B of the PA 67 1915(b)Waiver. The SMA monitors MCOs to ensure that they comply with 42 CFR 431.55 sub part D relating to Program Impact, Access and Quality. This is accomplished via a review of following components:

- Choice
- Marketing
- Enrollment/ Disenrollment
- Program Integrity
- Information to Beneficiaries
- Grievance
- Timely Access
- PCP Capacity
- Coordination/Continuity
- Coverage/ Authorization
- Provider Selection
- Quality of Care

The OMAP Bureau of Managed Care Operations(BMCO), which has oversight of the HealthChoices Agreements with the Managed Care Organizations (MCOs) has a designated HIV/AIDS waiver coordinator. That individual coordinates the enrollments and disenrollments of the HIV/AIDS waiver consumers with the Office of Long-Term Living (that has oversight of the HIV/AIDS waiver) and ensures that the BMCO core teams monitor the MCOs to ensure compliance with the HIV/AIDS requirements in the HealthChoices Agreements.

When an HIV/AIDS waiver participant is determined eligible for enrollment in the MCOs, the OLTL notifies BMCO. OLTL sends a copy of the approval letter which outlines the approved waiver services to the participant as well as the MCO.

Each waiver participant is assigned a Case Manager at the MCO to manage the participant’s services. The OLTL works with the MCO through BMCO if there is additional information needed to ensure ongoing eligibility or if there are specific issues regarding a participant’s services. OLTL communicates with the BMCO waiver coordinator if assistance is needed.

BMCO monitors ongoing waiver services through record reviews as part of their regular on-site monitoring process to ensure that service plans are up to date and appropriate waiver services are being provided. Monitoring results are reported to OLTL and used to address performance measures as part of the quality improvement strategy.

The OLTL and BMCO meet on an ongoing basis to discuss ongoing issues, monitoring and improvement activities.

## 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
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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## 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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*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 prior authorization policies prior approved by the Quality Management Division in BMCO through the formal Prior Authorization Review Committee**

**Data Source** (Select one):

**Record reviews, on-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 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"/>	
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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 type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
Number and percent of MCOs that meet contractual obligations

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Performance Monitoring**

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:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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. Oversight of the Managed Care Organizations (MCOs) is provided by the Bureau of Managed Care Operations (BMCO) within the Department of Public Welfare. Each of the MCOs is monitored under a Core Team, a matrix management model that is a cross-functional group of staff with a variety of skills and experiences. This group works as a team to provide oversight of the MCOs through both ongoing and quarterly comprehensive monitoring, as well as provide technical assistance to a specific MCO.

The Core Team Manager serves as the primary point of contact for all MCO-specific issues or concerns and is responsible for utilizing Core Team Members and their analyses to promote performance improvement. The Core Team also includes a Contract Monitor. The Contract Monitor’s primary responsibility is to evaluate the MCO’s performance in designated areas of the contract. Making up the remainder of the team are Lead Division Representatives, whose primary responsibility is to evaluate the MCO’s operation for specific performance requirements relevant to the work for that Lead Division. Together, the team manages and monitors a specific plan to make certain contractual, regulatory and programmatic requirements are met and that the members are ensured access to care and quality services. The Core Teams facilitate quarterly monitoring meetings with the MCOs to discuss MCO-specific monitoring results, and also produce annual reports and conduct biannual meetings with the MCOs to discuss general issues. Reporting for the AIDS Waiver performance measures is handled through the cBMCO waiver coordinator who receives reports from the core teams in BMCO’s Division of Monitoring and Compliance. Performance measure reports are issued to the Office of Long Term Living’s (OLTL) Office of Quality Management, Metrics & Analytics (QMMA). The core teams also initiates and follows-up on all Corrective Action Plans (CAPs) that result from monitoring or report analysis of reports.

For information regarding the Office of Quality Management, Metrics and Analytics (QMMA), and the Quality Improvement Strategy, please refer to Appendix H for detailed information.

**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.

When the performance measures identify Managed Care Organizations (MCOs) that are not meeting their requirements related to review of participant individualized service plans and Quality Assurance and Quality Improvement activities as outlined in the contractual agreement, BMCO sends the MCO written notification of outstanding issues with a request for a corrective action plan (CAP). The CAP is due to the BMCO within a mutually agreed time frame appropriate to the issues. BMCO staff reviews and accepts/rejects the CAP. Monitoring by BMCO occurs to ensure the CAP was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP.

When BMCO discovers prior authorization policies that were not prior approved by the Quality Management Division in BMCO through the formal Prior Authorization Review Committee, a CAP is required from the MCO accordingly.

- ii. **Remediation Data Aggregation**

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

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

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

**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.

**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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	HIV/AIDS	21	<input type="text"/>	<input checked="" 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="checkbox"/> Intellectual Disability 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 type="checkbox"/>	Intellectual Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/> 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 with symptomatic HIV or AIDS over the age of 21 who live in one of the 67 mandatory managed care counties and who are deemed eligible for medical assistance in accordance with Title XIX, by applying the Special Income Eligibility provisions (300% Federal Benefit Rate)

Individuals that receive Medical Assistance hospice are not eligible for the HIV/AIDS waiver.

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

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). 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

- 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	800
Year 2	800
Year 3	800
Year 4	800
Year 5	800

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

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

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

Table: B-3-b

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

## 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:

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

The waiver provides for the entrance of all eligible persons.

## 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 (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
 Medically needy 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 State Plan are included.

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***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

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- 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 7)**

*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. 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:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- 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 uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- 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 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- 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 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- 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-5: Post-Eligibility Treatment of Income (5 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

- e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-5-a 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 (6 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

- f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-5-a 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 (7 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

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. 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).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

**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: 1

- 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:*

- 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:*

- 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:

One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences OR

Two years of case work experience including one year of experience performing assessments of client's functional ability to determine the need for institutional or community-based services and a bachelor's degree which include or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology or other related social sciences OR

One year assessment experience and a bachelor's degree with social welfare major OR

Any equivalent combination of experience or training including successful completion of 12 semester credit hours of college level courses in sociology, social welfare, psychology, gerontology or other related social sciences.

The equivalency statement under "Minimum Requirements" means that related advanced education may be substituted for a segment of the experience requirement and related experience may be substituted for required education except for the required 12 semester hours in the above majors.

Registered Nurse requirements: Licensed under PA Department of State, per 49 PA Code Chapter 21 (State Board of Nursing) and have three years of professional experience in the field of medical assistance, health care services or human services.

Physicians

Licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code, with Certificate of Added Qualifications in Geriatric Medicine, and must subscribe to a chronic care model of care.

- 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.

In order to enter the Aids Waiver individuals are assessed to need the services associated with one of two levels of care (Hospital or Nursing Facility).

To be determined to meet the Hospital level of care an individual must require daily or more frequent nursing services provided by a skilled health professional or a trained informal caregiver as well as monitoring of the patient's condition by a skilled health professional on a daily or more frequent basis. The monitoring must include intensive nursing assessment and/or the venapuncture for lab studies. Service activities and monitoring are of the intensity requiring an acute care hospital bed in the absence of home and community-based waiver services.

To be determined Nursing Facility level of care an individual must have an illness, injury, disability or medical condition diagnosed by a physician; and as a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board that are ordered by, and provided under, the direction of a physician; and the care and services are either skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or health-related care and services that are not as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and are usually available only through institutional facilities.

The community Physician individual's PCP (MD or DO), Certified Nurse Practitioners (CRNP), or Physician's Assistants (PA) must complete the physician's section of the HIV/AIDS waiver application indicating the level of care required for the individual to live safely in the community. The physician then certifies the medical need for the waiver services that are documented on the application as well as the accuracy of the medical information provided. The individual's PCP (MD or DO), Certified Nurse Practitioners (CRNP), or Physician's Assistants (PA) then indicates the services required by the individual, as listed on the HIV/AIDS waiver application.

- 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.

The level of care instrument used to evaluate HIV/AIDS Waiver applicants includes the option of selecting among two levels of care depending on the individual's level of need. The tool is initially completed by licensed community Physicians, Certified Nurse Practitioners, or Physician's Assistants.

Each of the HIV/AIDS waiver level of care categories requires a different tool to evaluate institutional care under the state plan. Since participants in the HIV/AIDS waiver can be in one of two categories, OLTL uses one tool to determine level of care for the waiver.

OLTL will further develop this section. See the evaluation of Level Care Section of as part of the HIV/AIDS waiver the work plan.

- 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:

Initial Level of Care Evaluation:

The participant first applies for Aids HIV/AIDS waiver services through the Pennsylvania Home and Community-Based Services 0192 AIDS Waiver Application Independent Enrollment Broker (IEB). The IEB sends the HIV/AIDS Waiver Application to the individual's PCP, CRNP or PA initially who completes the Physician's Certification for the 0192 HIV/AIDS Waiver indicating certifies the applicant's diagnosis and recommends the applicant's level of care recommendation.

OLTL staff review all level of care evaluations and make the final determination on the level of care. OLTL staff (including a Social Workers, RN's and/or a Physician) participate in cross reviews of Aids HIV/AIDS waiver applications to ensure inter-rater reliability. OLTL staff utilize a checklist to review Aids HIV/AIDS waiver application(s) in order to ensure level of care (LOC), Choice of Care (COC) and Plan of Care (POC) are completed for each individual.

Annual Reevaluation:

Enrolled participants are reevaluated at least annually or more often if needed. The OLTL staff sends an HIV/AIDS Waiver Physician Certification Form to the individual, the individual's case manager and the individual's physician, which must be completed and returned to OLTL. OLTL staff send the Certification Form at a minimum of 45 days prior to annual reevaluation and follow up if the form is not returned. For individuals receiving services through MCO's, the individual's MCO case manager assists the participant and their physician in completing the HIV/AIDS Waiver Physician Certification Form. The process for reevaluation is the same as the initial evaluation.

- 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*):

Office of Long-Term Living staff maintain a computer-based alert system to inform staff of upcoming LOC reevaluation dates. OLTL staff send the Certification Form to participants, their case manager and their physician at a minimum of 45 days prior to annual reevaluation and follow up if the form is not returned.

- 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 by
- OLTL Bureau of Individual Support/Participant Operations
  - Managed Care Organizations
  - Provider agencies

## 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**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant’s/waiver participant’s level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 all new enrollees who have level of care determination, prior to receipt of waiver services.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:**

**The number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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 checked="" 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 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 initial LOC determinations that adhered to specifications**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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="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 checked="" 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 annual redeterminations of LOC that adhered to specifications**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" 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. Additional information on the Office of Quality Management & Analytics (QMMA) can be found in Appendix H.

**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.

Sub-assurance aia, aib, aic:

The Quality Management Division (QMD) within the office of Quality Management, Metrics & Analytics reviews data reports on Level of Care (LOC) for the performance measures. This waiver’s participants are enrolled through the State Medicaid Agency (OLTL); the Division of Direct Supports (DDS) enrolls participants. The QMD notifies DDS of all non-compliance areas and requests a Quality Improvement Plan (QIP) for correction. See Appendix H for more information on QIPs.

**ii. Remediation Data Aggregation**

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

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

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**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.

## Appendix B: Participant Access and Eligibility

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### 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).

When an individual is determined to require a specified level of care, Office of Long-Term Living Staff will provide the applicant or his or her legal representative:

- a. Any feasible alternatives under the waiver; and
- b. Give the applicant the choice of either institutional or home and community-based services Title 6 PA code Chapter 3.3.
- c. OLTL will provide an opportunity for a fair hearing for individuals who are denied the service(s) of their choice or the provider(s) of their choice.

Documentation of the participant's choice is contained on the Physician Certification Form.

- 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.

The form used to document recipient freedom of choice between institutional and home and community-based services is maintained by the Office of Long Term Living in the participant's file.

## Appendix B: Participant Access and Eligibility

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### 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):

Providers will make waiver documents available in different languages upon request, at no charge. Language assistance will be provided by the provider without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing.

All providers are required to have and implement policies and procedures for participants with limited English proficiency to ensure meaningful access to language services as required by 55 Pa. Code Chapter 52.

## Appendix C: Participant Services

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### 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
Extended State Plan Service	Home Health Services
Extended State Plan Service	Specialized Medical Equipment and Supplies
Other Service	Nutritional Consultations
Other Service	Personal Assistance Services

## 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:**

Home Health Services

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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 Health Services include home health care aides and nursing.

Home Health Care Aide - services are provided by a home health aide who is supervised by a Registered Nurse (RN). The RN supervisor must reassess the participant situation bi-weekly. Home health activities include: performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment, assisting with exercises taught by an RN, Licensed Practical Nurse (LPN), or licensed physical therapist.

Nursing - services must be performed by an RN or LPN. 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." Services must be ordered by a physician and are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. The physician's order must be obtained every sixty (60) days for continuation of service. Skilled nursing is individual, and can be continuous, intermittent, or part time nursing services based on individual's assessed need.

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

Home Nursing Visits – supplemental home nursing visits beyond the maximum number of visits permitted through the state plan. Nursing visits provided through the waiver can only be authorized by OLTL, after a denial is obtained from prior authorization, for services beyond regular state plan. Waiver authorized nursing visits will be reviewed at intervals not to exceed sixty (60) days.

Home Health Aide Visits – supplemental home health aide visits beyond the maximum number of visits permitted through the state plan. Home Health aide visits provided through the waiver can only be authorized by OLTL, after a denial is obtained from prior authorization, for services beyond regular state plan. Waiver authorized nursing visits will be reviewed at intervals not to exceed sixty (60) days.

The Case Manager is responsible for verifying that the State Plan and/or private insurance limitations have been exhausted prior to funding services through the AIDS Waiver. Documentation must be maintained in the individual's file by the Case manager. This documentation must be updated annually. Home Health Aide Services cannot be billed at the same time as Personal Assistance Services.

Home Health services may only be funded through the waiver when the services are not covered by the State Medicaid Plan or private insurance. This may be because the Medicaid State Plan or insurance limitations have been reached, or the service is not covered under the State Medicaid Plan or private insurance.

Service is limited to needs determined during the assessment and identified in the participant's service plan.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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	Licensed Practical Nurse
Agency	Home Health Agency
Individual	Home Health Aide
Individual	Registered Nurse

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Extended State Plan Service**

**Service Name: Home Health Services**

**Provider Category:**

Individual ▾

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications****License** (specify):

Licensed under PA Department of State, per 49 PA Code Chapter 21 (State Board of Nursing)

**Certificate** (specify):

Certification as required by specific profession or discipline, per 42CFR Part 484

**Other Standard** (specify):
**Verification of Provider Qualifications****Entity Responsible for Verification:**

PA Department of State Board of Nursing  
**Frequency of Verification:**  
 Every Two Years

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**  
**Service Name: Home Health Services**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart F. Chapter 601 and subpart A. Chapter 51.

**Certificate (specify):**

Per 42CFR Part 484

Medicare Certification.

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**  
**Service Name: Home Health Services**

**Provider Category:**

Individual

**Provider Type:**

Home Health Aide

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart F. Chapter 601 and Subpart A. Chapter 51

**Certificate (specify):**

Certification as required by specific profession or discipline, per 42CFR Part 484

**Other Standard (specify):**

Staff: Supervision by a registered nurse

Minimum of 60 hours of basic training must be completed during first 3 months of employment (May be waived if documentation of completion of related training and/or is able to demonstrate competency in all skill areas required in the basic training). Training must meet Medicare certification requirements

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service****Service Name: Home Health Services****Provider Category:**

Individual ▾

**Provider Type:**

Registered Nurse

**Provider Qualifications****License (specify):**

Licensed under PA Department of State, per 49 PA Code Chapter 21 (State Board of Nursing)

**Certificate (specify):**

Certification as required by specific profession or discipline, per 42CFR Part 484

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

PA Department of State Board of Nursing

**Frequency of Verification:**

Every Two Years

**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:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:****Category 1:**

14 Equipment, Technology, and Modifications ▾

**Sub-Category 1:**

14032 supplies ▾

**Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Items shall be specific to a participant's individual needs and not be approved to benefit the public at large, staff, significant others or family members. This service includes the following

components:

Specialized medical equipment, technology and supplies include:

- devices, controls, or appliances, specified in the service plan, that enable participants to increase, maintain, or improve their ability to perform activities of daily living;
- devices, controls, or appliances that enable, increase, maintain, or improve the ability of the participant to perceive, control, or communicate with the environment in which they live;
- items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- such other durable and non-durable medical equipment not available under the State Medicaid Plan that is necessary to address participant functional capabilities; and
- necessary medical supplies not available under the State Medicaid Plan.

All items shall meet applicable standards of manufacture, design and installation.

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

The accessibility adaptations, equipment, technology and medical supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Medicaid Plan and exclude those items that are not of direct medical or remedial benefit to the participant.

Any specialized medical equipment, technology or supplies that exceed \$500 requires a review by the Office of Long- Term Living.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

Medical equipment and supplies are approved after the provider dispenses beyond the maximum number permitted through the state plan. Providers will be approved for equipment and/or supplies after receiving a denial from program exception or prior authorization.

**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	Pharmacy
Agency	Medical Equipment and Supply Company

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Meet state regulations under 55 PA Code 1123 regarding participation for medical supplies

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency  
**Frequency of Verification:**  
 At Time of Service

**Appendix C: Participant Services**

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

**Service Type:** Extended State Plan Service  
**Service Name:** Specialized Medical Equipment and Supplies

**Provider Category:**

Agency

**Provider Type:**

Medical Equipment and Supply Company

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Agency:

Meet state regulations under 55 PA Code 1123 regarding participation for medical supplies

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

At Time of Service

**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:**

Nutritional Consultations

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Category 2:**

**Category 3:**

**Category 4:**

**Sub-Category 1:**

11040 nutrition consultation

**Sub-Category 2:**

**Sub-Category 3:**

**Sub-Category 4:**

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):**

All Services are provided by a Registered Dietitian

- The Assessment is a face to face interview with the consumer and any appropriate caregivers to evaluate certain information to determine whether the consumer is at nutritional risk and to formulate a nutritional diet plan and follow-up
- The nutritional assessment includes but is not limited to the following:  
Weight History: including usual weight, desired weight, weight prior to HIV/AIDS diagnosis, etc.
- General Physical assessment: Including anthropometric measurements and functional status
- Intake assessment including determination of energy and protein needs, use of alternative foods, special diets and supplements
- Problems effecting intake such as allergies, intolerances, physical or medical
- Problems, social factors etc.
- Metabolic problems or problems effecting absorption
- Diagnostic tests
- Effect of medications
- Other relevant factors
  
- Annual Reassessment

- The nutritional counseling is a face to face encounter with the consumer and any appropriate caregiver
- Counseling sessions will be tailored to the consumer’s needs and overall nutritional status.
- Counseling sessions may cover area as:
  - o The impact of nutrition and the management of HIV/Aids
  - o Actions needed to promote an adequate balanced diet for weight
  - o Maintenance and prevention of vitamin and mineral deficiencies
  - o Avoidance of drugs and alcohol
  - o Actions needed to control or alleviate nausea, vomiting, diarrhea or constipation
  - o Food management including food shopping, budgeting, storage, and preparation
  - o Monitoring of previously recommended dietary interventions
  - o Special nutritional needs and value of supplements
  - o Nutritional interventions and support options to include misconceptions the consumer may have or self prescribed diets that may be harmful
  - o The relationship of medication and diet
  - o The consumer’s nutritional diet care plan

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

Individuals are assessed for services, frequency of services and duration of services based upon needs and are identified and documented in the individual’s service plan. Services are to be provided in 15-minute blocks with each waiver client limited to 90 minutes of nutritional consultations per calendar month.

**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	Nutritional Consultation Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Nutritional Consultations**

**Provider Category:**

Individual

**Provider Type:**

Nutritional Consultation Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Minimum of a Baccalaureate degree granted by a US regionally accredited college or university.  
 Completion of current Didactic Program in Dietetics minimum academic requirements as approved by the American Dietetic Association.  
 Must meet all federal, state and local requirements. Title 55 PA Codes Chapter 1101.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Every Two Years

## 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:**

Personal Assistance Services

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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):**

- Non-medical personal care (eating, bathing, dressing, personal hygiene), general household activities/chores (light housekeeping tasks, preparing meals, grocery shopping, laundry), cuing to prompt the participant to perform a task, and companion services to assist a functionally impaired individual who cannot be safely left alone;
  - Health maintenance activities are provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan;
  - Routine wellness services to enable adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities;
  - Overnight Personal Assistance Services provide intermittent or ongoing, awake, overnight assistance to a participant in their home for up to eight hours. Overnight Personal Assistance services require awake-staff;
  - Chore services needed to maintain the home in a clean, sanitary and safe environment – 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.
- Specify applicable (if any) limits on the amount, frequency, or duration of this service:**  
The waiver does not pay for the personal transportation costs incurred by the Personal Assistance Services worker.

Chore services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

There is no duplication of any State Medicaid Plan services. Personal Assistance Services cannot be provided simultaneously with Home Health Care Aide Services.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

Visits will be authorized by OLTL, in 15-minute blocks of time with a minimum visit of 4 units (1 hour), and a maximum of 40 units per day, or 280 units per week.

**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 Care Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Personal Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (*specify*):

Licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries), under Act 69

**Certificate** (*specify*):

**Other Standard** (*specify*):

## Agency:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101
- Commercial General Liability Insurance
- Professional Liability Errors and Omissions Insurance
- Worker's Compensation Insurance, when required by Pennsylvania statute
- Must meet requirements of 55PA Code

## Personal Assistance Services workers must:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Have training in the following areas:
  - o first aid;
  - o fire prevention and safety;
  - o explanation and demonstration of commonly performed tasks;
  - o policies regarding abuse, neglect, and exploitation;
  - o basic nutrition;
  - o skin breakdown and its prevention (class must be given by a medical professional and documented by provider).
  - o CPR
- Have the required skills to perform personal assistance services as specified in the participant's service plan;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances; and

The Personal Assistance Services worker must be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.

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

OLTL, PA Department of Health

**Frequency of Verification:**

Every Two Years

**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:

Participants in managed care organizations receive case management services directly from the MCO or from local AIDS Service Organizations that are enrolled in the MCO's provider network.

Those participants who are not enrolled in managed care (dual eligible) receive case management services from local AIDS Service Organizations that are enrolled in the Medicaid State Plan as AIDS Targeted Case Managers.

## 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):

Criminal history background checks are required for all individuals performing home health or personal assistance services.

The home health/personal assistance agency is responsible for securing criminal history background checks for their employees. The agency must have a system in place to document that the criminal history background check was conducted

Criminal history clearances are obtained from the Pennsylvania State Police within 30 work days from the date that the employee/provider initiates services to the participant. The Pennsylvania State Police access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC) for this information. In the interim of securing the written results of the criminal history, the agency obtains a written certification from the employee that confirms either the employee has never been convicted of a felony or discloses prior convictions.

The employee attests to understanding that if the certification is contradicted by the criminal clearance results, the employee may face immediate dismissal from employment in the waiver program. The decision to dismiss an employee based on criminal background check results rests solely with the employer of record.

OLTL reviews provider personnel records as part of the every two year monitoring to ensure that criminal history checks are documented.

- 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):

Written results of child abuse clearances are required for all direct care workers providing services in homes where children reside. These clearances are obtained from the Office of Children, Youth and Families, DPW-Childline and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717)783-6211 within 30 work days from the date the employee/provider initiates services to the participant.

In the interim of securing the written results of child abuse clearances, the provider of service will obtain written certification from the employee/provider which confirms that the employee has not, within five (5) years immediately preceding the date of enrollment into the waiver program been named on a central child abuse registry as being a perpetrator of founded or indicated child abuse.

The agency is responsible for securing child abuse clearances for their employees. The agency must have a system in place to document that the child abuse clearance was conducted.

OLTL reviews provider personnel records as part of the every two year monitoring to ensure that abuse registry screenings are documented.

## 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).**

**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.*

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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.*

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- 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.

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- Other policy.**

Specify:

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- 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:

All willing and qualified providers have the opportunity to enroll as waiver providers at any time using the following process. OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available upon request from the OLTL, and are also available to potential providers online through the DPW website [www.dpw.state.pa.us](http://www.dpw.state.pa.us).

For an agency or individual provider to be enrolled as a new service provider they must contact OLTL. OLTL staff will guide the agency or provider of service in preparing an enrollment application. This application must be submitted to the OLTL for approval. The following documents must be completed as part of the enrollment application:

- 1) Provider Enrollment Information Form
- 2) OLTL HCBS Waiver agreement with Rider A
- 3) Medicaid Home and Community Based Waiver Program Survey
- 4) PROMISe Enrollment Form including Medical Assistance Provider Agreement

OLTL staff will provide technical assistance to the prospective provider in obtaining the appropriate documentation. Once OLTL receives a completed packet, OLTL staff will send a written response to the prospective provider within 60 days. The written response will include a request for more information, acceptance of enrollment, or denial of enrollment.

The MCOs either enroll qualified providers into their provider networks (as in the case of home health agencies) or will enter into an out of network agreement with a qualified provider if necessary to provide a waiver service.

## 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

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*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 newly enrolled providers who meet required licensure and initial QP standards prior to service provision**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

#### Administrative Data

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 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 (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 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 non-MCO providers continuing to meet applicable licensure/certification and applicable waiver standards following initial enrollment**

**Data Source (Select one):**

**Provider performance monitoring**

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 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="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of newly enrolled MCO providers who meet licensure and/or certification standards prior to service provision to waiver participants.**

**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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

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

**Performance Measure:**

**Number and percent of MCO providers continuing to meet required licensure and/or certification standards following initial enrollment**

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 newly enrolled waiver providers who meet initial QP standards prior to service provision**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*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 providers meeting provider training requirements.**

**Data Source (Select one):**

**Training verification records**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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. The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency’s (OLTL) regional provider monitoring agents. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the on-site review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider is reviewed every 2 years, at a minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application. See Appendix A, Quality Section, for additional information on BMCO’s Core Teams and Appendix H for more information on QMMA and how QMMA and BMCO work together.

**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.

Subassurance a.i.a- Before a provider in a non-mandatory managed care county is enrolled as a qualified waiver provider; written documentation must be provided to the State QP Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or certified provider is required to submit written documentation that it meets initial qualified waiver requirements that are not part of its licensure or certification. When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL sends a letter to the provider informing it of the need for the licensure or certification, and a blank Standards Implementation Plan (StIP) for the provider to complete. The letter warns the provider that it has no more than 30 calendar days to obtain appropriate licensure or certification before OLTL begins disenrollment procedures to terminate the provider as a qualified waiver provider. The provider must complete the StIP to concisely state how and when the provider will obtain the needed licensure or certification. The provider has 15 business days to submit its StIP to OLTL. OLTL reviews and approves the StIP within 30 business days of submission. If the StIP is insufficient; OLTL works with the provider to develop an appropriate StIP. If a staff member does not meet necessary state licensing or certification standards, the staff member cannot provide service to waiver participants until the provider verifies staff compliance with state licensing and/or certification requirements. The QMET verifies the approved StIP action steps are in place according to the timeframe written in the StIP. If the provider is unable or unwilling to obtain the appropriate license or certificate the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

When a provider in a mandatory managed care county is determined to not meet required licensing and certification requirements, BMCO informs the MCO to discontinue using the provider until the provider obtains the required licensure/certification. The participant must be provided with a choice of alternative providers.

Subassurance a.i.b- This subassurance does not apply to the AIDS Waiver as all providers are required to be licensed or certified.

Subassurance a.i.c- The QMET monitoring tool will ascertain if the provider has completed training in accordance with waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that the state policies and procedures for verification that training is conducted in accordance with state and waiver requirements is followed. If a QMET does not verify the provider training, OLTL is made aware through the QMET tracking database. Each QMET reviews provider records to assure the training was completed according to waiver specifications. If a provider has not met training requirements, the provider is required to submit a StIP. The provider needs to demonstrate through the StIP that it can fulfill all the training requirements within 30 days of the QMET on-site review. The provider has 15 business days to submit a completed StIP to the appropriate regional QMET, and OLTL reviews and approves the StIP within 30 business days of submission. The QMET verifies the StIP action steps are in place according to the time frame as written in the StIP. If the StIP is insufficient; OLTL works with the provider to develop an appropriate StIP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider training qualifications, the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

BMCO’s Core Team is responsible for remediation with the MCO. The team manages and monitors specific plans to make certain waiver programmatic requirements are met, utilizing Corrective Action Plans (CAPs) for remediation.

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 checked="" 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. 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.

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## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

---

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

---

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

---

**Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

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## Appendix C: Participant Services

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Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The HIV/AIDS waiver provides Personal Assistance, Home Health Aide, Home Health - Nursing, Specialized Medical Equipment and Supplies and Nutritional Consultation Services. With the exception of Nutritional Consultation services, which are provided in outpatient clinics, services are provided to participants in their own homes or in the homes of family members or friends. Services are not provided in provider-owned or operated settings.

Areas in which OLTL is compliant:

- 42 CFR §441.301 (c) (5) (CMS Prohibited Settings) Home and community-based settings do not include a nursing facility, institution for mental diseases, ICF/ID and hospitals.
- 42 CFR §441.301 (c) (5) (v) In summary, settings that are presumed to have the qualities of an institution include: settings in a publicly or privately owned facility that provides inpatient treatment; settings on the grounds of, or immediately adjacent to, a public institution; and settings that have the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS.
- 42 CFR §441.301 (c) (4) (i) The setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- 42 CFR §441.301 (c) (4) (ii) Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- 42 CFR §441.301 (c) (4) (iii) Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.
- 42 CFR §441.301 (c) (4) (iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- 42 CFR §441.301 (c) (4) (v) – Facilitates choice regarding services and who provides them.
- 42 CFR §441.301 (c) (4) (vi) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- 42 CFR §441.301 (c) (4) (vi) (B) (1) through (3) The individual has privacy in their unit, which includes: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors; individuals sharing units have a choice of roommates in that setting; and individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- 42 CFR §441.301 (c) (4) (vi) (C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- 42 CFR §441.301 (c) (4) (vi) (D) Individuals are able to have visitors of their choosing at any time.
- 42 CFR §441.301 (c) (4) (vi) (E) The setting is physically accessible to the individual.

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Individual Service Plan

- 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:*

In addition to physicians, a Certified Nurse Practitioner or Physician's Assistant can complete the initial service plan. All service plans are reviewed and approved by OLTL by Registered Nurses and Social Workers with consultation from the OLTL Medical Director.

## 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:*

## 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.

The Individual Service Plan (ISP) development process is a collaborative process between the participant and their PCP. The participant has the right to include family, friends, advocates or others as part of their ISP development.

A key step in developing an ISP is to gather information that reflects the needs and preferences of the participant. Information may also be obtained from family, friends, advocates or others that are identified and chosen by the participant. The services available through the waiver are outlined on the Pennsylvania Home and Community-based Services HIV/AIDS Waiver Application.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

## 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):

Office of Long-Term Living and Office of Medical Assistance Programs will further define roles and responsibilities in the service plan development process as part of the HIV/AIDS waiver work plan.

(a) who develops the plan, who participates in the process, and the timing of the plan (how and when it is updated);

The HIV/AIDS waiver applicant and his/her family or others invited by them to participate, completes an application for the Aids HIV/AIDS waiver indicating the need for services. The applicant and their physician, with the assistance of the Aids waiver applicant and others invited by them, develops the service plan indicating the services and supports required to meet the individual's needs. The application for Aids HIV/AIDS waiver services, including the proposed service plan, are sent to OLTL staff for review. Service plans are approved at the time of enrollment in the Waiver, annually and when an individual's needs change. For those individuals enrolled in managed care, the service plan approved by OLTL is sent to the MCO to assist in the development of a comprehensive plan of care.

(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 physician uses an assessment tool that includes documentation of the HIV/AIDS waiver applicant's level of care. The tool also includes the services available within the HIV/AIDS waiver. The physician works with the applicant to consider their needs for the services, and develop a service plan that will meet the needs, preferences, and goals of the applicant including the type, the frequency of services, and the duration of services. The physician also attests to the accuracy of the medical information submitted.

(c) how the participant is informed of the services that are available under the waiver;

The services available through the waiver are defined on the Pennsylvania Home and Community-based Services HIV/AIDS Waiver Application. Individuals are informed of services by OLTL. Upon approval, participants receive an enrollment letter outlining acceptance in the program and the services available through waiver funding and the specific services authorized for the participant.

(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;

The physician develops the initial service plan with the prospective participant and others invited by the participant. The services are identified on the HIV/AIDS waiver application and the physician reviews and agrees with the participant on the need for the services. The application also includes questions that the physician reviews with the participant related to health and safety, nutritional status and clinical condition filled out by the physician and participant. This information is returned to OLTL staff for review and assistance by the participant in completing the provider choice part of the application. Each individual is afforded the ability to choose the provider of services.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

(e) how waiver and other services are coordinated;

Services are currently coordinated for Aids HIV/AIDS waiver participants via targeted case management managers through in the Medicaid sState plan Plan or assistance of OLTL staff. Aids HIV/AIDS waiver participants in managed care organizations receive case management services through the MCOs.

Based on the ISP, the case manager or OLTL staff locates resources and makes referrals or arrangements for treatments and support services. The case manager or OLTL staff intervenes on behalf of the recipient to obtain needed services from appropriate agencies, private individuals or other service providers. The case manager or OLTL staff provides support to the participant.

The case manager is responsible to ensure that there is coordination between services in the ISP, including maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and,

Upon authorization of the ISP, the case manager or OLTL staff provides information to service providers of the participant's choice regarding the type, scope, amount, duration, and frequency of the service authorized. Also included should be demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being provided. The case manager or OLTL staff communicates service plan changes to the participant and the appropriate service provider to ensure that service delivery is consistent with the approved ISP.

Case managers or OLTL staff is are responsible for monitoring the health and welfare of the participant and the quality of the participant's service plan.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

(g) how and when the plan is updated, including when the participant's needs change.

At a minimum of every 365 days, OLTL obtains documentation of continued need from the HIV/AIDS waiver participant's physician.

If an individual requires changes to their service plan, then the individual meets with their physician or contacts OLTL to review and discuss additional services. All changes to the service plan are made according to the individual's needs.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

## 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.

The service plan process includes identifying potential risks to the participant. Initially, the physician discusses potential risks with the participant during the development of the service plan. The case manager and the participant will identify strategies to mitigate such risks allowing participants to live as they choose in the community while assuring their health and welfare. The needs and preferences of the participant will be considered when identifying any risks or possible services that would assist the participant with addressing these risks. A specific service or combination of services may benefit the participant in these types of circumstances.

All participants are required to have individualized back up plans and arrangements to cover the services they need when the regularly scheduled service worker is not available. Strategies for back up plans encourage the use of family and friends of the participants' choice and/or agency staff, based on the needs and preferences of the participant.

OLTL, in coordination with other state agencies and stakeholders, is currently enhancing the risk assessment and risk management protocols that are incorporated into service plan development. OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

## 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.

Waiver participants may freely choose from any able and willing MA enrolled/certified provider. Participant/representatives receive a list of all qualified MA enrolled/certified providers from which to make their selection by OLTL upon initial enrollment, recertification or upon request.

Participants are also given the toll free Participant Helpline number of the Office of Long-Term Living (OLTL) so they may contact OLTL should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The toll-free line information is provided to participants at time of enrollment and at annual reevaluations.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 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):

The HIV/AIDS waiver application contains a description of service(s) available in the waiver. The physician submits the HIV/AIDS waiver applicant's initial, completed application to OLTL staff for approval. Subsequently, within 365 days of the initial enrollment, OLTL staff send reevaluation documents for completion to waiver participants and physicians.

OLTL staff follow-up with participants to ensure the documents are received within the appropriate timeframe. OLTL staff then review the documents to ensure participants continue to meet eligibility requirements and approve participant service plans. This process is followed for all waiver participants including those participants within managed care organizations.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

## 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:*

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- 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:*

Provider Agencies and Managed Care Organizations

## 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.

The Case Manager assists the HIV/AIDS Waiver participant in coordinating approved services indicated on their service plan. OLTL contacts the chosen provider of service and verbally informs them of the approval. The OLTL then sends an approval letter informing the provider of the service, rate and frequency for services. OLTL obtains the documentation of services from the provider in order to verify that the services are being provided as indicated in the service plan. If an individual requires changes to their service plan, the individual will again meet with their physician for assessment. All changes to the service plan are indicated on the physician's plan along with the individual preferences.

OLTL reviews case managers', physicians' and providers' documentation to ensure the individual's needs are being met.

The managed care organizations are responsible for implementing and monitoring the individual service plans of HIV/AIDS Waiver participants within managed care. The case manager is responsible for ensuring that the service plan is always up to date and that the appropriate waiver services are being provided. The case manager is also responsible for ongoing communication with the waiver participant.

OLTL surveys HIV/AIDS Waiver participants annually and after their first 4 months of participation. Specific questions in the survey ask whether participants are receiving the services that are in their plan and whether they need additional services. Participants are able to access the OLTL Participant Helpline for assistance. The information is provided with the survey letters and part of the survey. Monitoring these two OLTL access points allows OLTL to assess service plan quality.

OLTL will further develop development of the Individual Service Plan as part of the HIV/AIDS waiver work plan.

- 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:*

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## 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**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

**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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 have Individual Service Plans (ISP's) that are adequate and appropriate to their needs, capabilities, and desired outcomes as indicated in the assessment.**

**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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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 Source (Select one):**

**Record reviews, on-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):

<i>each that applies):</i>	<i>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 checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<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 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 waiver participant satisfaction survey respondents who reported unmet need/needs.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Survey Data**

<b>Responsible Party for data collection/generation(check each that applies):</b>	<b>Frequency of data collection/generation(check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<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 (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 type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of waiver participants who have service plans that address the participant's goals as indicated in the assessment.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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 checked="" type="checkbox"/> Representative Sample Confidence Interval

		= +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<input type="text"/>	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

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

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 Individual Service Plans and related service plan activities that comply with how the participant is informed of the services that are available under the waiver.**

**Data Source (Select one):**

**Record reviews, on-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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**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> ):

<i>each that applies):</i>	<i>each that applies):</i>	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of Individual Service Plans and related service plan activities that comply with who develops the plan, who participates in the process and the timing of the plan development.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

<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 Source (Select one):

Record reviews, on-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 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 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: +/- 5%
	<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 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 waiver participants whose Individual Service Plan (ISP) included a risk factors assessment and needs assessment instrument.**

**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 checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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 Source (Select one):**

**Record reviews, on-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 checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	+/-5% <input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of Individual Service Plans and related service plan activities that comply regarding how waiver services and other non-waiver services are coordinated.**

**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 checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 Individual Service Plan was revised as needed, to address changing needs.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<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 Source (Select one):**  
**Record reviews, on-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (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 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 Individual Service Plans (ISP's) reviewed and revised before the AIDS Waiver participant's annual review date.**

**Data Source (Select one):**

**Record reviews, on-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 checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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 Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Aggregation and Analysis:**

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

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 participant satisfaction survey respondents reporting the receipt of all services in Individual Service Plan (ISP).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Survey Data**

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

**Performance Measure:**

**Number and percent of complaints received regarding non-receipt of 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Twice a Year	

**Data Source (Select one):**

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

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**  
 Number and percent of waiver participants who received services in the type and amount as specified in the Individual Service Plan.

**Data Source** (Select one):  
**Record reviews, on-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<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 checked="" type="checkbox"/> Other Specify: Twice a Year	

**Data Source** (Select one):  
**Other**  
 If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval

		= [ ]
<input type="checkbox"/> <b>Other</b> Specify: [ ]	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: [ ]
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: [ ]
	<input type="checkbox"/> <b>Other</b> Specify: [ ]	

**Data Aggregation and Analysis:**

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

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional care and waiver services.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Performance Measure:**

Number and percent of waiver participants whose records documented that a list of waiver services and providers was provided to, and discussed with, the waiver participant.

Data Source (Select one):

Other

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data	Frequency of data	Sampling Approach( <i>check</i>
----------------------------	-------------------	---------------------------------

collection/generation( <i>check each that applies</i> ):	collection/generation( <i>check each that applies</i> ):	<i>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 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 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. See Appendix A, Quality Section, for additional information on BMCO’s Core Teams and Appendix H for more information on QMMA and how QMMA and BMCO work together.

**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.  
OLTL staff (including Social Workers, RNs and/or a Physician) participate in cross reviews of initial Aids waiver applications, including the service plan, to ensure inter-rater reliability, as well as review annual re-evaluations. If a waiver participant’s

Individual Service Plan (ISP) is discovered to be deficient in accordance with the sub-assurances, the Bureau of Individual Support (BIS) staff contacts the appropriate party responsible for development of the ISP. Such contact could involve the physician, a Targeted Case Manager, the BMCO waiver coordinator or other OLTL staff. The deficiency is expected to be corrected within 3 working days. Deficiencies are documented by the Bureau of Individual Supports (BIS), Division of Direct Services (DDS) and reported to QMMA. When QMMA finds multiple issues, a Quality Improvement Plan is requested from BIS to correct barriers to compliance. See Appendix H for more information about QIPs.

Additionally, deficiencies that are identified through BMCO’s monitoring of MCOs are addressed through Corrective Action Plans (CAPs)

If the New or Annual Participant Satisfaction Survey responses indicate that waiver participants have unmet needs, QMMA initiates further analysis comparing with other data sources and develops a Quality Improvement Plan (QIP) or System Improvement Plan (SIP) if appropriate.

**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 checked="" 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. 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.

**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.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (1 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (2 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (3 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (4 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (5 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (6 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (10 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (11 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-1: Overview (12 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-1: Overview (13 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (2 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (3 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (4 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (5 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (6 of 6)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

**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.

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with OLTL policies. A participant will have his or her rights to file a fair hearing request discussed at time of enrollment, annually during the ISP annual review meeting and at any time the participant requests to change services or add new services.

The IEB is required to provide information on due process and appeal rights to the applicant utilizing OLTL issued standard forms when the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services as an alternative to the institutional care
2. The individual is denied his or her preference of waiver or nursing facility services.

The Service Coordinator is required to provide information due process and appeal rights to the participant utilizing OLTL issued standard forms any time the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services as an alternative to institutional care
2. The individual is denied his or her preference of waiver or nursing facility services.
3. The participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).
4. The participant is denied the choice of willing and qualified Waiver provider(s).
5. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's ISP or when the participant is involuntarily terminated from participant direction.

The Service Coordinator(or IEB where applicable) are required to make all such notices in writing utilizing OLTL issued documents. Should the participant/applicant choose to file an appeal, they must do so with the agency that made the determination being questioned. 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." The agency which receives the appeal from the participant will forward it to the Department's Bureau of Hearings and Appeals for action.

It is the responsibility of the Service Coordinator(or IEB where applicable) to provide any assistance the participant/applicant needs to request a hearing. This may include the following:

- Clearly explaining the basis for questioned decisions or actions.
- Explaining the rights and fair hearing proceedings of the individual or participant.
- Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the forms.
- Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and providing information to assist the applicant or participant to locate legal services available in the county.

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).

The Service Coordinator is required to provide an advance written notice of at least 10 calendar days to the participant anytime the Service Coordinator initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice shall contain a date that the appeal must be received by the Service Coordinator to have the services that are already being provided at the time of the appeal continue during the appeal process.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the Service Coordinator, 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 Service Coordinator. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant.

Fair hearing requests are collected in a statewide database and due process is monitored by OLTL.

## **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.

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## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Office of Long-Term Living (OLTL) is responsible for the operation of the grievance/complaint system.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OLTL operates a toll free Participant Helpline, 1-800-757-5042. The helpline was established for enrolled participants in OLTL waivers and programs to express dissatisfaction with services or issues they were unable to resolve on a local level.

All Helpline calls are responded to within one (1) business day. Calling the helpline is not a prerequisite for the participant to request a fair hearing. Participants are informed and notified of their right to appeal as a separate process from the helpline.

The types of complaints that can be addressed are:

- Complaints/grievances regarding provision and timeliness of services
- Reports of alleged abuse, neglect, or exploitation
- Status of waiver or program eligibility

The process used for operation of the complaint system:

OLTL takes calls on the toll free line. The OLTL call taker enters call information into the tracking data base. The OLTL call taker forwards grievances and complaints immediately to the appropriate OLTL Program Specialists or the BMCO Waiver Coordinator for follow-up, research, and resolution. This information is also tracked in the data base. At a minimum, OLTL will initially respond to grievance and complaint calls within one business day. Additional follow-up and resolution timelines may vary depending on the issue or issues to be resolved.

Reports of potential abuse/neglect are followed up in accordance with OLTL Policy as outlined in Appendix G-1: 1-2 and G-2, Response to Critical Events or Incidents and Restrictive Interventions.

Case Manager informs and notifies participants that their right to appeal is a separate process from calling the toll free helpline. Case Manager shares this information during home visits and through ongoing discussions with the participant.

Participants in managed care also fall under specific requirements for MCOs. The MCOs must follow the federal BBA definition of a complaint, which is: A dispute or objection regarding a participating health care provider or the coverage, operations, or management policies of an MCO, which has not been resolved by the MCO and has been filed with the MCO or with DOH or DOI including but not limited to:

- o A denial because the requested service/item is not a covered benefit; or
- o A failure of the MCO to meet the required timeframes for providing a service/item; or
- o A failure of the MCO to decide a complaint or grievance within the specified time frames; or
- o A denial of payment by the MCO after the service has been delivered because the service/item was provided without authorization by a provider not enrolled in the MA program; or

- o A denial of payment by the MCO after the service has been delivered because the service/item provided is not a covered service/item for the member.
  - There are three levels of complaints
  - o First level must be resolved within 45 days of the complaint being filed (the MCO must complete an expedited review within 48 hours if the member's life, health, or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process)
  - o Second level review (this is filed if the member does not agree with the first level decision) must be resolved within 45 days of the complaint being filed
  - o External review is conducted by DOI or DOH if the member does not agree with the first and second level decision
- BMCO's complaint and grievance coordinator does an annual on-site review at every MCO to verify that the MCO is meeting all contractual obligation related to processing and resolving complaints.
- The MCO must report all complaints to BMCO quarterly. Reports include an indicator for any complaint received related to a waiver service. BMCO forwards the required complaint information to QMMA for inclusion with other complaint data for the HIV/AIDS Waiver.

## Appendix G: Participant Safeguards

### Appendix G-1: 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).

The HIV/AIDS Waiver participant, family members, service providers and others connected with the participant can report incidents to OLTL. Administrators and employees of home health care agencies and facilities are mandatory reporters of incidents as outlined in the OLTL incident management bulletin issued April, 2010.

The agency providing services to the HIV/AIDS Waiver participant need to investigate potential incidents to determine if it meets one of the reportable categories below:

Reportable incidents or critical events include:

- 1) Death, Injury, or Hospitalization – any incident that occurred as a result of the provision of Home and Community- Based Services or lack of provision of documented services.
- 2) Provider and Staff misconduct – deliberate, willful unlawful or dishonest activities related to the provision of Home and Community- Based Services
- 3) Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation on a participant.

Types of abuse include (but are not necessarily limited to):

- (a) physical abuse (a physical act by an individual that may cause physical injury to a participant);
  - (b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a participant); i.e. gestures, facial expressions, menacing body language, etc.
  - (c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching on a participant); and,
  - (d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate a participant).
- 4) Exploitation – an act of depriving, defrauding or otherwise obtaining the personal property of a participant in an unjust or cruel manner, against one's will, or without one's consent or knowledge for the benefit of self or others.

5) Neglect – the failure to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of a participant.

6) Service interruption -- Any event that results in temporary or permanent service interruption or termination by the service provider agency or staff that may place the home and community-based service participant at risk. In the event of temporary or permanent service interruption or termination, the service provider agency must have a plan for temporary stabilization.

The state prohibits the use of restraints and restrictive interventions within the AIDS Waiver. The use of restraints or restrictive interventions is a reportable incident under the provider and staff misconduct category of reportable incidents.

Managed Care Providers are required to use qualified MA providers licensed under Department of Health which are governed under Act 28 for mandatory reporting of abuse, neglect or exploitation. Any reported incidents of abuse, neglect, and exploitation will be investigated by the Department of Health.

OLTL will further develop the reporting of Critical Incidents as part of the HIV/AIDS waiver work plan.

Reporting process and timeframes:

Incidents are reported using an Incident Report form, emailing the report to an OLTL specified incident reporting email box.

All incidents where there is an interruption in services or the participant is at imminent risk must be reported within 24 hours. All other incidents must be reported within 48 hours. The service provider must forward to OLTL a follow-up related to the disposition of the incident report within five days of the initial report.

AIDS Waiver participants and their representatives may notify their service providers or OLTL regarding any observed, alleged incident.

Direct service providers for HIV/AIDS Waiver participants respond with appropriate immediate action and complete the OLTL Incident Report form and submit within two business days.

OLTL will follow-up with the HIV/AIDS Waiver participant and service provider and investigate the specifics of the incident, including fact finding, the sequence of event, the potential causes and assess service planning to determine needed changes and documentation.

- 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.

OLTL provides information at enrollment and annual recertification of HIV/AIDS Waiver participants concerning protections from abuse, neglect, and exploitation and how to report these incidents and upon request.

Participants and others may report incidents on the OLTL Participant Helpline which is a statewide toll free number that is available to program participants, legal representatives, personal assistants, and family members. The Participant Helpline number has been widely publicized and is included on the annual survey mailing described below.

OLTL annually surveys HIV/AIDS Waiver participants and asks whether participants know how to report abuse, neglect, and exploitation. The surveys are reviewed for possible system improvements such as training or creating pamphlets for participants and families.

- 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 timeframes for responding to critical events or incidents, including conducting investigations.

OLTL's Quality, Metrics, and Analytics Office (QMMA) receives all reportable incidents submitted from any source. Incidents involving abuse, neglect and exploitation are reported concurrently to the Protective Services division within the Department of Aging and OLTL.

QMMA is responsible for evaluating reports by reviewing all incidents received through the RA-Incident mailbox.

QMMA determines the Priority Level (urgent/non-urgent) and recommends the method/process of investigation such as:

Onsite investigation  
Telephone investigation  
No further action

Investigation Priority:

- Non-Urgent –The details of the incident suggests an issue where the participants safety is not at risk and immediate attention is not required. The provider agency has initiated an investigation. The documentation reflects an investigative process is underway. Complete documentation is required within 5 business days.

- Urgent-The details of the Incident suggest immediate action is necessary to assist in safeguarding the participant's health and welfare. The investigative process/ documentation must be initiated within one business day.

#### Investigation Types:

- Onsite investigation- The provider and/or the participant onsite visit is conducted for fact finding. The incident facts, sequence of events, interview of witnesses and observation of the participant and/or environment is required. Onsite investigations will be conducted by OLTL staff when the incident places the consumer at immediate risk, and/or the incident investigation is lacking information or clarification is required and cannot be obtained through an alternative route.
- Telephone investigation- Review of the Incident Report (IR) revealed facts are missing or additional information is required and can be obtained through conducting a telephone investigation.
- No further action - meets all of these 3 conditions:
  - 1) The facts and sequence of events is outlined with sufficient detail
  - 2) Preventative action through the service plan is implemented and documented
  - 3) The participant is not placed at any additional risk.

OLTL's Quality Management, Metrics, and Analytics (QMMA) notifies the Bureau of Managed Care Operations (BMCO) within the State Medicaid Office if an incident is reported for Aids waiver participants in Managed Care Organizations. OLTL will further develop this section. See the Health and Welfare section of the work plan.

#### Incident Resolution:

The investigation of all incidents must be completed within 45 days of receiving the incident report. If the timeframe is not met the details regarding the delay will be documented in the incident reporting database. QMMA reviews and approves extension requests.

Incident resolutions are documented in the incident database for purposes of tracking and trending for quality improvement. Resolutions indicate the action provided to support the consumer, reduce the risk to the consumer, and/or initiate policy or protocol changes that will reduce risk or prevent reoccurrence of the incident. The following resolution categories are used:

- Adjusted Service Plan
- Agency protocols established or adjusted
- 
- Other (can be used in cases where the incident has no resolution, the narrative must support the decision).

The QMMA "Incident Reporting and Investigations" internal protocol outlines these responsibilities in more detail.

- 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.

The Agencies responsible for oversight include: the Office on Long-Term Living and Office of Medical Assistance Programs.

The Office of Long-Term Living maintains a statewide database on all participants who were referred for investigation of an incident. Reports related to incidents are run monthly, quarterly and annually. The results are aggregated for tracking and trending purposes to detect patterns for possible remediation. The results of the reports are presented at the Quarterly Quality Management Meetings (QM2) and the Quality Council which meeting quarterly to discuss and recommend quality improvement measures.

OLTL will further develop the reporting of Critical Incidents as part of the HIV/AIDS waiver work plan.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Office of Long-Term Living is notified about unauthorized use of restraints or seclusion through service providers, managed care organizations, and participants through the OLTL incident reporting policy.

Also, OLTL provides a statewide toll free Participant Helpline for enrolled participants to register complaints. The participant enrollment form and handbook contain the toll free number. If a complaint is filed regarding the use of a restraint or restrictive intervention, OLTL completes an incident report and follows the established protocol for investigation and remediation as outlined in G-1-d.

- The use of restraints 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.** 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). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

#### 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 Office of Long-Term Living is notified about unauthorized use of restrictive interventions through service providers, managed care organizations, and participants through the OLTL incident reporting policy.

Also, OLTL provides a statewide toll free Participant Helpline for enrolled participants to register complaints. The participant enrollment form and handbook contain the toll free number. If a complaint is filed regarding the use of a restraint or restrictive intervention, OLTL completes an incident report and follows the established protocol for investigation and remediation as outlined in G-1-d.

- 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.

- 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:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

#### c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Office of Long-Term Living is notified about unauthorized use of restraints or seclusion through service providers, managed care organizations, and participants through the OLTL incident reporting policy.

Also, OLTL provides a statewide toll free Participant Helpline for enrolled participants to register complaints. The participant enrollment form and handbook contain the toll free number. If a complaint is filed regarding the use of a restraint or restrictive intervention, OLTL completes an incident report and follows the established protocol for investigation and remediation as outlined in G-1-d.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.
- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of 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).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## 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.

- 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.

## Appendix G: Participant Safeguards

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

- c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

- 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).

- 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:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the State:

- 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.

## 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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

- a. **Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 complaints by type: Basic service delivery issues**

**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 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 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 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="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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

**Performance Measure:**

**Number and percent of MCO waiver participants who participated in disease management through HIV counseling or clinics**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of incidents of abuse, neglect and exploitation, as well as other reportable incidents, for which corrective actions were verified within required timeframe, including the use of restraints and restrictive interventions.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

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

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

Performance Measure:

**Number and percent of waiver participants who indicate knowledge of how to report abuse, neglect and exploitation including the use of restraints and restrictive interventions.**

**Data Source** (Select one):

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

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of waiver participants with more than three reported incidents of abuse, neglect and exploitation in a calendar year including the use of restraints and restrictive interventions.**

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

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

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

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

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**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 type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number of reportable incidents by type: abuse, neglect and exploitation, as well as other reportable incidents including the use of restraints and restrictive interventions

**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 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 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 type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

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

**Performance Measure:**

Number and percent of new waiver participants who were informed of the reporting process for abuse, neglect and exploitation

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of complaints addressed within required timeframe regarding basic service delivery issues**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

<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 Source (Select one):**

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

If 'Other' is selected, specify:

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <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 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 MCO waiver participant who recieved physical exams in accordance with state Medicaid/ waiver policy

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Performance Measure:**

Number and percent of incidents of abuse, neglect and exploitation, as well as other reportable incidents, investigated within required timeframe, including the use of restraints and restrictive interventions.

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of complaints investigated regarding basic service delivery issues.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

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

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number and percent of incidents substantiated by type: abuse, neglect and exploitation, as well as other reportable incidents, including the use of restraints and restrictive interventions.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> 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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percent of incidents requiring investigation by type: abuse, neglect and exploitation, as well as other reportable incidents, including the use of restraints and restrictive interventions.

**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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Continuously and</b>	<input type="checkbox"/> <b>Other</b>

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

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

--	--

- b. **Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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.*

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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.*

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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.*

- 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. For additional information regarding the Quality Management Efficiency Teams (QMETs), please refer to Appendix C.

See Appendix A, Quality Section, for additional information on BMCO's Core Teams and Appendix H for more information on QMMA and how QMMA and BMCO work together.

**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.

For incidents involving non-managed care participants, when it is discovered that an incident was not acted upon in accordance with waiver standards, OLTL staff that discovered the incident was not reported, immediately direct the Provider or case manager to report the incident utilizing OTLT Incident reporting protocols. If immediate action is required to protect the Health and Welfare of the individual the provider is instructed to take such action, When a pattern of not reporting is determined a referral is made to the Quality Management Efficiency Unit (QMEU) for review of the providers incident protocols and implementation. As issues are discovered, Standards Implementation Plans (StIPs) are required.

If the Office of Quality Management, Metrics and Analytics (QMMA) discovers that a complaint was not acted upon in

accordance with waiver standards, QMMA contacts BIS leadership and requests an investigation be conducted as to why the complaint did not meet waiver standards. BIS has 5 business days to report back to QMMA on the root cause as to why the complaint did not meet waiver standards. BIS must also develop a quality improvement plan (QIP) to address the root cause and work with QMMA to ensure the strategy is implemented.

If it is discovered that a waiver participant does not know how to report a complaint or incident of abuse, neglect or exploitation, BIS staff contacts the non-MCO AIDS waiver participant to provide information about how to report abuse, neglect or exploitation, and obtain written verification that the participant understands and is knowledgeable on how to report a possible incident or complaint of abuse, neglect or exploitation.

For AIDS waiver participants served by managed care organizations, the Bureau of Managed Care Operations (BMCO) within the Medicaid Office contacts the applicable MCO regarding the need to provide appropriate information to the waiver participant. BMCO will instruct the MCO to contact the participant, review how to report abuse, neglect or exploitation, and obtain written verification that the participant understands and is knowledgeable on how to report a possible incident or complaint of abuse, neglect or exploitation. The MCO is then responsible for providing the written verification to BMCO and BIS staff.

BMCO’s Core Team is responsible for remediation with the MCO of complaints and incidents not acted upon in accordance with waiver standards. The team manages and monitors specific plans to make certain waiver programmatic requirements are met, utilizing Corrective Action Plans (CAPs) for remediation.

Information collected by BMCO regarding the Health & Welfare performance measures and remediation is channeled to OLTL for aggregation and analysis, and included in waiver reporting.

**ii. Remediation Data Aggregation**

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

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

**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.

**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 QIS 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 OIS* 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## 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.

The Office of Long Term Living (OLTL) includes the Bureau of Quality Management, Metrics, and Analytics (QMMA) which was created to support the other OLTL Bureaus and programs in maintaining continuous quality improvement. QMMA is composed of :

- \* Quality Management Division
  - \* Quality Management Unit (QMU)
  - \* Quality Management Efficiency Unit (QMU)
  - \* Quality and Compliance Unit (QMU)
- \* Metrics and Analytics Division (M&A)
  - \* Data Collection and Reporting Section
  - \* Metrics and Analytics Section

The goals of Quality Management, Metrics & Analytics (QMMA) are:

- \* To conduct quality monitoring of long term living programs and services to ensure compliance with Federal and State

regulations

- \* To use data analysis to measure effectiveness of program design and operations,
- \* To recommend strategies for Continuous Quality Improvement
- \* To establish a quality improvement focus within OLTL based on the Six Waiver Assurances:  
 Level of Care  
 Qualified Providers  
 Service Plan  
 Health and Welfare  
 Financial Accountability, and  
 Administrative Authority
- \* To support OLTL management in development and implementation of policies and protocols to achieve desired outcomes
- \* To oversee the development of system wide training for staff, providers and participants
- \* To work effectively with other OLTL Bureaus, internal and external stakeholders, other State Agencies, contracted consultants, the Quality Council, and other individuals or entities regarding Quality Management activities.

The mission of QMMA is to meet these goals in a manner which will bring about maximization of the quality of life, functional independence, health and well being, and satisfaction of participants in OLTL programs and waivers.

QMMA’s work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to OLTL systems, then monitoring system improvement changes for effectiveness. For the AIDS Waiver, QMMA works with the Bureau of Individual Support (BIS) and the Bureau of Provider Support within OLTL, as well as the Bureau of Managed Care Operations (BMCO) within the Department of Public Welfare related to the quality oversight of the AIDS Waiver. Information collected by BMCO regarding the performance measures and remediation is channeled to OLTL for aggregation and analysis, and included in waiver reporting.

The process for trending discovery and remediation information (data) begins with QMMA receiving the data from various points in the OLTL system and from BMCO. Database aggregation reports are created for QMMA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. Additionally, QMMA reviews information from field observations and record reviews to support the information gathered from administrative data.

Provider remediation activities are documented in Standards Implementation Plans (StIPs) which are requested from providers by the QMETs to correct non-compliance issues. Information on BMCO’s Corrective Action Plans with the MCOs are provided to QMMA also. Internal remediation activities are documented in Quality Improvement Plans (QIPs) which are requested by the Quality Management Division for internal remediation within a single bureau. The StIPs, QIPs and CAPs are then aggregated for QMMA to review, track trends, and suggest system changes. System changes are considered for the completion of a System Improvement Plan (SIPs) to document and implement system-wide changes that may include both OLTL and BMCO.

In order to prioritize the quality management issues, QMMA has assigned each of the six Waiver Assurances to a Quality Management (QM) liaison to review the various quality reports through tracking and trending, and determine possible causes of aberrant data or compliance issues. Quality data is gathered for performance measures from numerous sources, including BMCO discovery and remediation activities, provider monitoring by the QMETs, etc., and aggregated for tracking and trending. The QM liaison makes initial recommendations and prioritizes issues for problem solving or corrective measures. The QM liaison reviews and responds to aggregated, analyzed discovery and remediation information collected on each of the assurances. In addition to trending and analyzing for each waiver, this structure allows QMMA to trend and analyze across multiple waivers.

QMMA internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review is implemented. The QMU summarizes the list of priorities and recommendations in a quarterly report to present to the Quarterly Quality Management Meeting (QM2). The QM2 participants consist of appropriate QMMA staff, OLTL Bureau directors (or designee) and internal subject matter experts. The comments from the QM2 are considered and included in a revised report for the Quality Council. The Quality Council is comprised of internal and external stakeholders, including BMCO, whose recommendations are reviewed by the Director of QMMA. The Director makes final recommendations as to action needed for system improvements to the Deputy Secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

**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 checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input 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.

QMMA assists BIS and BMCO in developing quality management improvement strategies for the needed system design changes. QMMA ensures the strategies are implemented, evaluating the effectiveness of the strategies against tracked and trended data. Additional reports to narrowly track the effect of system changes are developed and produced by Metrics & Analytics, or provided by BMCO and given to QMU for analysis. The analyses are reviewed in the same manner as other reports through the QM liaison, creating a cycle of continuous quality improvement.

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

The Quality Improvement Strategy (QIS) is evaluated on an on-going and continuous basis through the implementation of the continuous quality cycle. Periodic evaluation also occurs every two years when the QIS is reviewed by the Quarterly Quality Management Meeting and the Quality Council.

The Quality Improvement System outlined also applies to the Aging (control number 0279) and Attendant Care (control number 0277) waivers. It is OLTL's intent to include this Quality Improvement Strategy into the renewal application for the additional waivers under its purview. The discovery and remediation data gathered during the implementation of QIS will be waiver specific and stratified. Because the renewals are staggered, the QIS will automatically receive a periodic evaluation during the point of the renewal.

## 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 methods used to ensure the integrity of payments made for waiver services include:

(a) An annual fiscal year audit of state government and providers of services conducted 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. All subrecipients (profit and nonprofit) are required to 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.

(b) 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.

(c) Recipients of Federal funds who are contracted directly through the State or are enrolled as MA providers of service are audited annually in accordance with the Single Audit Act, as amended. Profit and 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. The waiver services are tested in accordance with both the compliance requirements set forth by the OMB Circular A-133 compliance supplement and by the DPW single audit supplement. These procedures are applicable to providers of service regardless of whether the provider is a public or a private organization.

(d) 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 known 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.

(e) If issues of fraud and abuse are found, OLTL through the DPW Office of General Counsel (OGC), will refer such situations to the DPW Office of Medical Assistance Programs (OMAP) Bureau of Program Integrity for review, investigation and necessary action.

(f) OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. OLTL reviews PROMISE reports and conducts quarterly reviews of services rendered through review of time sheets where applicable and participant interviews.

Depending on the findings of reviews, remediation may require:

- OLTL monitoring and training of provider staff in documentation of services rendered
- Suspension of new provider enrollment
- Termination of waiver provider agreement
- Requiring the provider to refund inappropriately billed amounts

If issues of fraud and abuse are found, OLTL through the DPW Office of General Counsel (OGC), will refer such situations to the DPW Office of Medical Assistance Programs (OMAP) Bureau of Program Integrity for review, investigation and necessary action.

The MCO is responsible for paying for HIV/AIDS Waiver services. Providers are required to file claims with the MCOs based on the claims processing requirements established by the MCO. As required by the HealthChoices Agreement, the MCOs are responsible for conducting Fraud, Abuse and Waste activities for these services the same as every other MA service they are responsible to provide.

## 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. (For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:

- a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)***

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 non-MCO provider submitting accurate claims for services authorized by the waiver and being paid for those services.**

**Data Source** (Select one):

**Record reviews, on-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 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="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 checked="" 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 type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of non-MCO claims coded as specified in the waiver application.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data	Frequency of data	Sampling Approach( <i>check</i>

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of capitation payments paid correctly for active waiver participants enrolled in MCO's**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 checked="" type="checkbox"/> Other Specify: Twice a year	

**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: Twice a year

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

- 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.

The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency’s (OLTL) regional provider monitoring agents. They conduct monitoring visits every 2 years with every provider of waiver services. The QMETs comprise of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET state coordinator, an OLTL employee. Using a standard monitoring tool which outlines the Financial Accountability as listed in the waiver, the QMET verifies each assurance during the on-site review. A random sample of provider employee and consumer financial records are reviewed to ensure compliance with waiver standards. Additionally, QMET conduct remediation activities as outlined in the waiver application.

See Appendix A, Quality Section, for additional information on BMCO’s Core Teams and Appendix H for more information on QMMA and how QMMA and BMCO work together.

**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.

If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/ Financial Bureau would initiate steps to recoup the overpayment.

If providers submit claims for services not covered by the waiver and are paid for those services with waiver funds, Bureau of Provider Supports initiates steps to recoup inaccurate payment. QMET works with provider to establish a Corrective Action Plan to prevent billing for unauthorized services. The Quality Management Efficiency Teams is the monitoring agent for OLTL. The QMET tracking database collects the information found by the QMETs for data analysis and aggregation purposes. Through this process, if a QMET discovers a claim does not meet correct payment methodology, the provider, with technical assistance of the QMET, develops a Standards Implementation Plan (STIP). The provider needs to demonstrate through the STIP that it can meet the all waiver financial accountability qualifications and resubmit the claim within 30 calendar days of the QMET review. QMET reviews adjusted claim submissions to assure that recoupment was done correctly. The provider has 15 business days to submit a completed STIP to the appropriate regional QMET, and the QMET reviews and approves the STIP within 30 business days of submission. If the STIP is insufficient; the QMET works with the provider to develop an appropriate STIP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

If BMCO determines capitation payments are paid incorrectly or OLTL reports the incorrect payment(s) to BMCO, the appropriate BMCO Core Team is responsible for remediation with the MCO. The team manages and monitors each specific managed care plan to make certain programmatic requirements are met and follows-up on repayment of incorrect capitation payments.

**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 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"/>

**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).

The Current Medical Assistance fee schedule is utilized for waiver services. The MA fee schedule is determined based on the rate-setting methodology set forth in our Medicaid state plan, under Attachment 4.19B. SMA staff is responsible for rate determination, and all new fees/fee changes are published in the Pennsylvania Bulletin, affording opportunity for public comment.

- 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:

Claims are paid through the State Medicaid Management Information System (MMIS) (PROMISE). The PROMISE system automatically verifies consumer and provider eligibility prior to the payment of a claim. For managed care enrollees, the MCO receives a capitation payment to cover the costs of both physical health and waiver service, and then reimburses its provider network using its negotiated rates and in accordance with approved procedures.

## 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, <https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp>

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:

Post-payment independent claims reviews. The Public Health & Human Services (PH HS) Comptroller Office, Medical Assistance (MA) Payment Review Division in the Office of the Budget performs an independent review of payments and related claims processed through PROMISE. These post-expenditure reviews evaluate compliance with applicable state and federal regulations, policies and procedures. A random sample of 1296 recipient claims is selected from all MA provider types. In addition, the selected recipient's corresponding claim history is reviewed to identify any payment errors.

When a claim for the Home and Community Based Services (HCBS) program is selected the Payment Review Division verifies recipient eligibility, validates that procedures were authorized, rates were appropriate and that no duplicate payments or frequency limit violations exist. Any discrepancies are reported to the Secretary for recovery and recommendations are made to take corrective action to prevent reoccurrence. In addition, the PHHS Comptroller Office assists with the federally mandated Medical Eligibility Quality Control (MEQC) review that is administered by the Office of Income Maintenance. Each month a sample of 128 recipients is selected for eligibility review. When a recipient that is enrolled in HCBS is selected for review, all claims for the month are reviewed to ensure that the recipient was eligible for the services provided and that no Third Party Liability (TPL) exists.

The OLTL staff completes financial/provider audits on 10% of the population each quarter. A random selection of participants is obtained. Letters to the service provider are sent requesting the past three months of progress notes, time sheets and check lists. Paid claims are reviewed to verify that they are coded and paid in accordance with the waiver reimbursement methodology, and that they correspond with the approved service plan. A quarterly audit form is completed to compare billed units and approved units and to follow up with the provider if any financial irregularities are identified. The audit form is then placed in the participant's chart and a list of completed audits is kept in a file drawer.

The MCO is responsible for paying for HIV/AIDS waiver services for individuals in managed care counties. Waiver Providers are required to file claims with the MCOs based on the claims processing requirements established by the MCO. MCO's receive a monthly capitation payment for each enrolled Medical Assistance participant. The MCO receives the individual service plan prior to providing services. BMCO utilizes encounter data submitted by the MCO to ensure the waiver services were provided in accordance with the comprehensive care plan.

- 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:

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- 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:

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- 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.

For individuals who are deemed eligible using the increased eligibility limits and reside in a mandatory managed care county, the State Medicaid Agency pays a capitation payment to the MCOs and the MCOs make payments to the contracted providers for services rendered.

The MCOs currently pay the majority of their PCPs using capitation (per member/per month). However, all other services are paid on a fee for service basis based on rates negotiated between the MCO and their providers.

## 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:

## 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:*

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

- 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:

**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:**Do not complete this item.**


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**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:

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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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: **Hospital, Nursing Facility**

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	2360.60	3445.00	5805.60	39664.00	8135.00	47799.00	41993.40
2	2431.35	3549.00	5980.35	40854.00	8379.00	49233.00	43252.65
3	2504.86	3655.00	6159.86	42079.00	8631.00	50710.00	44550.14
4	2579.10	3765.00	6344.10	43342.00	8890.00	52232.00	45887.90
5	2657.15	3878.00	6535.15	44642.00	9156.00	53798.00	47262.85

**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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	800	100	700
Year 2	800	100	700
Year 3	800	100	700
Year 4	800	100	700
Year 5	800	100	700

**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.

Average length of stay is based on history of 372 reports.

**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:

Based on actual history of utilization and establishing a percentage each service is utilized compared to all services. The number of participants is projected from history and average participants entering the waiver and average participants leaving the waiver. The rates are adjusted for cost of living increases for services.

- 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:

Based on actual history, including the deduction of Medicare drug costs, as reported through claims history. Three (3) percent increase is added each year based on the increase for the G and G' to keep the prime a consistent increase between G and D. D' is less than G' because per diem payments made to institutions may not include all services that are available to residents through Medicaid such as medical equipment etc.

- 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:

Based on Institutional Rates with a three percent cola increase per year. The rates have increased by an average of three percent over the last two years.

- 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:

Based on claims history, including the deduction of Medicare drug costs with a three (3) percent increase each year.

**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
Home Health Services
Specialized Medical Equipment and Supplies
Nutritional Consultations
Personal Assistance Services

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Health Services Total:</b>							<b>8558.10</b>
Home Health Aide	<input type="checkbox"/>	Visit	5	9.00	40.73	1832.85	
Capitated	<input checked="" type="checkbox"/>	Month	20	9.00	20.80	3744.00	
Nursing	<input type="checkbox"/>	Visit	5	9.00	66.25	2981.25	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>3219.75</b>
Capitated	<input checked="" type="checkbox"/>	Month	10	9.00	10.40	936.00	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Purchase	5	3.00	152.25	2283.75	
<b>Nutritional Consultations Total:</b>							<b>68463.90</b>
Nutritional Consultations	<input type="checkbox"/>	Visit	45	9.00	30.38	12303.90	
Capitated	<input checked="" type="checkbox"/>	Month	150	9.00	41.60	56160.00	
<b>Personal Assistance Services Total:</b>							<b>1808235.00</b>
Capitated	<input checked="" type="checkbox"/>	Month	650	9.00	241.10	1410435.00	
Personal Assistance Services	<input type="checkbox"/>	15 Min	85	1000.00	4.68	397800.00	
<b>GRAND TOTAL:</b>							<b>1888476.75</b>
Total: Services included in capitation:							1471275.00
Total: Services not included in capitation:							417201.75
<b>Total Estimated Unduplicated Participants:</b>							<b>800</b>
<b>Factor D (Divide total by number of participants):</b>							<b>2360.60</b>
Services included in capitation:							1839.00
Services not included in capitation:							521.50

Average Length of Stay on the Waiver:

271

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Health Services Total:</b>							<b>8814.15</b>
Home Health Aide	<input type="checkbox"/>	Visit	5	9.00	41.95	1887.75	
Capitated	<input checked="" type="checkbox"/>	Month	20	9.00	21.42	3855.60	
Nursing	<input type="checkbox"/>	Visit	5	9.00	68.24	3070.80	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>3316.20</b>
Capitated	<input checked="" type="checkbox"/>	Month	10	9.00	10.71	963.90	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Purchase	5	3.00	156.82	2352.30	
<b>Nutritional Consultations Total:</b>							<b>70519.95</b>
Nutritional Consultations	<input type="checkbox"/>	Visit	45	9.00	31.29	12672.45	
Capitated	<input checked="" type="checkbox"/>	Month	150	9.00	42.85	57847.50	
<b>Personal Assistance Services Total:</b>							<b>1862430.50</b>
Capitated	<input checked="" type="checkbox"/>	Month	650	9.00	248.33	1452730.50	
Personal Assistance Services	<input type="checkbox"/>	15 Min	85	1000.00	4.82	409700.00	
<b>GRAND TOTAL:</b>							<b>1945080.80</b>
Total: Services included in capitation:							1515397.50
Total: Services not included in capitation:							429683.30
<b>Total Estimated Unduplicated Participants:</b>							<b>800</b>
<b>Factor D (Divide total by number of participants):</b>							<b>2431.35</b>
Services included in capitation:							1894.20
Services not included in capitation:							537.10
Average Length of Stay on the Waiver:							271

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Health Services Total:</b>							<b>9079.65</b>
Home Health Aide	<input type="checkbox"/>	Visit	5	9.00	43.21	1944.45	
Capitated	<input checked="" type="checkbox"/>	Month	20	9.00	22.07	3972.60	
Nursing	<input type="checkbox"/>	Visit	5	9.00	70.28	3162.60	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>3415.50</b>
Capitated	<input checked="" type="checkbox"/>	Month	10	9.00	11.03	992.70	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Purchase	5	3.00	161.52	2422.80	
<b>Nutritional Consultations Total:</b>							<b>72628.65</b>
Nutritional Consultations	<input type="checkbox"/>	Visit	45	9.00	32.23	13053.15	
Capitated	<input checked="" type="checkbox"/>	Month	150	9.00	44.13	59575.50	
<b>Personal Assistance Services Total:</b>							<b>1918763.00</b>
Capitated	<input checked="" type="checkbox"/>	Month	650	9.00	255.78	1496313.00	
Personal Assistance Services	<input type="checkbox"/>	15 Min	85	1000.00	4.97	422450.00	
<b>GRAND TOTAL:</b>							<b>2003886.80</b>
Total: Services included in capitation:							1560853.80
Total: Services not included in capitation:							443033.00
<b>Total Estimated Unduplicated Participants:</b>							<b>800</b>
<b>Factor D (Divide total by number of participants):</b>							<b>2504.86</b>
Services included in capitation:							1951.07
Services not included in capitation:							554.00
<b>Average Length of Stay on the Waiver:</b>							<b>271</b>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Health Services Total:</b>							<b>9351.90</b>
Home Health Aide	<input type="checkbox"/>	Visit	5	9.00	44.51	2002.95	
Capitated	<input checked="" type="checkbox"/>	Month	20	9.00	22.73	4091.40	
Nursing	<input type="checkbox"/>	Visit	5	9.00	72.39	3257.55	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>3517.95</b>
Capitated	<input checked="" type="checkbox"/>	Month	10	9.00	11.36	1022.40	
Specialized Medical Equipment and							

Supplies	<input type="checkbox"/>	Purchase	5	3.00	166.37	2495.55	
<b>Nutritional Consultations Total:</b>							74817.00
Nutritional Consultations	<input type="checkbox"/>	Visit	45	9.00	33.20	13446.00	
Capitated	<input checked="" type="checkbox"/>	Month	150	9.00	45.46	61371.00	
<b>Personal Assistance Services Total:</b>							1975591.00
Capitated	<input checked="" type="checkbox"/>	Month	650	9.00	263.46	1541241.00	
Personal Assistance Services	<input type="checkbox"/>	15 Min	85	1000.00	5.11	434350.00	
<b>GRAND TOTAL:</b>							2063277.85
Total: Services included in capitation:							1607725.80
Total: Services not included in capitation:							455552.05
<b>Total Estimated Unduplicated Participants:</b>							800
<b>Factor D (Divide total by number of participants):</b>							2579.10
Services included in capitation:							2009.66
Services not included in capitation:							569.44
<b>Average Length of Stay on the Waiver:</b>							271

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Health Services Total:</b>							9631.80
Home Health Aide	<input type="checkbox"/>	Visit	5	9.00	45.84	2062.80	
Capitated	<input checked="" type="checkbox"/>	Month	20	9.00	23.41	4213.80	
Nursing	<input type="checkbox"/>	Visit	5	9.00	74.56	3355.20	
<b>Specialized Medical Equipment and Supplies Total:</b>							3624.30
Capitated	<input checked="" type="checkbox"/>	Month	10	9.00	11.71	1053.90	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Purchase	5	3.00	171.36	2570.40	
<b>Nutritional Consultations Total:</b>							77053.95
Nutritional Consultations	<input type="checkbox"/>	Visit	45	9.00	34.19	13846.95	
Capitated	<input checked="" type="checkbox"/>	Month	150	9.00	46.82	63207.00	
<b>Personal Assistance Services Total:</b>							2035406.00
Capitated	<input checked="" type="checkbox"/>	Month	650	9.00	271.36	1587456.00	
Personal Assistance Services	<input type="checkbox"/>	15 Min	85	1000.00	5.27	447950.00	
<b>GRAND TOTAL:</b>							2125716.05
Total: Services included in capitation:							1655930.70
Total: Services not included in capitation:							469785.35

<b>Total Estimated Unduplicated Participants:</b>	<b>800</b>
<b>Factor D (Divide total by number of participants):</b>	<b>2657.15</b>
Services included in capitation:	2069.91
Services not included in capitation:	587.23
<b>Average Length of Stay on the Waiver:</b>	<input type="text" value="271"/>