Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Department of Human Services, Commonwealth of Pennsylvania

Submission Date:	March 29, 2011

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:
The OBRA waiver has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. Services available through the OBRA waiver include Adult Daily Living Services (Basic and Enhanced), Community Integration, Home Health Services (Nursing, Physical Therapy, Occupational Therapy and Speech and Language Therapy), Personal Assistance Services, Prevocational Services, Residential Habilitation, Residential Habilitation Enhanced Staffing, Respite, Service Coordination, Structured Day Habilitation, Structured Day Habilitation Enhanced Staffing, Supported Employment, Therapeutic and Counseling Services, Personal Emergency Response System, Home Modifications, Specialized Medical Equipment and Supplies, Vehicle Modifications, Assistive Technology and Community Transition Services – services designed to support individuals to live more independently in their homes and communities

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.

State:	
Effective Date	

1. Request Information

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. Waiver Title (*optional*): OBRA Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
●	**Renewal (5 Years) of Waiver #**	0235	
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
●	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2011

E.2 Approved Effective Date *(CMS Use):*

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 under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
✓	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	
	Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)	

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

☐	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):
	☐ §1915(b)(1) (mandated enrollment to managed care) ☐ §1915(b)(3) (employ cost savings to furnish additional services)
	☐ §1915(b)(2) (central broker) ☐ §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:*
✓	Not applicable

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 OBRA Waiver provides services to adults with developmental disabilities who are Medicaid eligible. The primary purpose of the waiver is to prevent inappropriate and unnecessary institutionalization by providing home and community-based services as a cost-effective alternative to institutional care. OBRA Waiver services enable participants to:

- Live in the most integrated community setting appropriate to their individual service requirements and needs.
- Exercise meaningful choices.
- Obtain the quality services necessary to live independently.

The Office of Long-Term Living (OLTL) Bureau of Individual Support has administrative responsibility for the OBRA Waiver. Intake and enrollment is performed as an administrative activity through a statewide contract with an Independent Enrollment Broker. Initial level of Care determinations are conducted through the local network of Area Agencies on Aging. Service Coordination is provided as a waiver service through local disability organizations that are enrolled as Medicaid providers. Direct services are provided through enrolled Medicaid providers.

The OBRA Waiver allows Pennsylvania to provide an alternative to institutional care by offering home and community based waiver services to individuals who require an Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) level of care. Pennsylvania has demonstrated, through the Nursing Home Transition (NHT) Initiative, a commitment to continue the successful transition of individuals to the community, who have, for various reasons, been living in nursing facilities and other types of institutional settings. Individuals with Other Related Conditions who reside in nursing facilities are "targeted" using the PASRR process. This process identifies whether an individual needs nursing facility care AND specialized services. The NHT initiative has been integral to assist the state in identifying individuals in nursing facilities who qualify for ICF/ORC LOC and want to receive services in the community. By using the NHT initiative, the state is able to assist the individuals leave the nursing facilities to get the services they need in the home and community-based setting of their choice.

- The NHT initiative does not require the person to be eligible for a certain LOC to be provided assistance to leave the institution. The NHT initiative assists all who have a barrier to returning to the community and who want to leave the institutional setting.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

●	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

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 overall systems improvement for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

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

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

●	Yes
○	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
●	**No**

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

☐	**Geographic Limitation**. A waiver of state wideness 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. S*pecify 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 state wideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (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) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of

the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, 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 throughout the application and in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Public Input for this waiver was obtained through the following means:

- The Community Living Advisory Committee (CLAC) provides ongoing feedback and communication regarding waiver issues. The CLAC meets every other month and includes representation from participants, family members, advocates, and providers.
- The Long-Term Care Sub Committee and Consumer Sub Committee of the Medical Assistance Advisory Committee also provides ongoing input and feedback on departmental waivers and services.

- The DPW manages a website that offers program and contact information about the waivers. Stakeholders can contact the OLTL via the OLTL supports email.
- The OLTL has a toll-free hotline number (1-800-757-5042) that stakeholders can use to provide feedback on an ongoing basis.

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 as 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:

First Name:	Allen
Last Name	Leesa
Title:	Executive Medical Assistance Director
Agency:	Office of the Secretary, Department of Human Services
Address 1:	P.O. Box 2675
Address 2:	Room 331, Health and Welfare Building, 625 Forster Street
City	Harrisburg
State	PA
Zip Code	17105-2675
Telephone:	(717) 787-2600
E-mail	leallen@pa.gov
Fax Number	(717) 772-2062

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	

Zip Code	
Telephone:	
E-mail	
Fax Number	

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: ___Bonnie L. Rose_____
State Medicaid Director or Designee

Date:	

First Name:	Leesa
Last Name	Allen
Title:	Executive Medical Assistance Director
Agency:	Office of the Secretary, Department of Human Services
Address 1:	P.O. Box 2675
Address 2:	Room 331; Health and Welfare Building, 625 Forster Street
City	Harrisburg
State	PA
Zip Code	17105-2675
Telephone:	(717) 787-2600
E-mail	lallen@pa.gov
Fax Number	(717) 772-2062

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 *(name of unit) (do not complete Item A-2*):	
	●	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). This includes administrations/divisions under the umbrella agency that has been	Office of Long-Term Living (OLTL)

		identified as the Single State Medicaid Agency. (*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. 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).*	

2. **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 OBRA Waiver.

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

The Secretary of the Department of Human Services, 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 policy staff meets regularly with the Executive Medicaid Director to review and gain consent on Waiver policies, rules and guidelines.

Descriptions of the functions of the operating divisions within the Department are available (through links) on the following Department of Human Services website http://www.dhs.state.pa.us/dhsorganization/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:

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

● **Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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 retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL retains authority for all administrative decisions and supervision of the organizations OLTL contracts with.

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL contracts with fifty-two (52) local Area Agencies on Aging to perform the initial level of care determination as specified in Appendix B-6. Thirty-three of these entities are Local/Regional non-state public agencies, while nineteen are Local/Regional non-governmental non-state entities.

OLTL also 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 OBRA 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, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider;
- Provide applicants with choice of receiving ICF-ORC institutional services, waiver services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form;
- Provide applicants with 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;
- Refer the applicant to the local AAA for the level of care determination;
- Assist the participant to complete the financial eligibility determination paperwork; and
- Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms.

OLTL also contracts with one Fiscal Employer/Agent (F/EA) to perform certain functions for the successful operation of participant direction.
These administrative functions delegated to the FMS by OLTL include:

- Execute Medicaid provider agreements with qualified vendors and support workers;
- Assist in implementing the state's quality management strategy related to FMS; and
- Provide written financial reports to the participant, the Service Coordinator and OLTL

	on a monthly and quarterly basis and as requested by the participant, Service Coordinator and OLTL. In addition to these delegated activities, the F/EA also serves to: • Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant; • Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation; • Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards; • Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees; • Assist participants in verifying support workers citizenship or alien status; • Distribute, collect and process support worker timesheets as verified and approved by the participant; • Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan; • Maintain funds for individual service budgets separately and with full accounting; • Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations; • Broker workers' compensation for all support workers through an appropriate agency; • Process all judgments, garnishments, tax levies or any related holds on workers' pay as may be required by federal, state or local laws; • Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually; and • Establish an accessible customer service system for the participant and the Service Coordinator. Performance of annual redeterminations of level of care is conducted by service coordination entities as described in Appendix C. Administration and oversight of these contracts falls within the purview of OLTL and the Executive Medicaid Director. The assessment methods used to monitor performance of contracted entities are described below in A-1-6 below.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

✓	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*

	As noted above, OLTL retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL also retains authority for all administrative decisions and supervision of non-state public agencies that conduct Waiver operational and administrative functions. Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates a component of the initial level of care assessment to determine clinical eligibility for waiver services to fifty-two (52) local Area Agencies on Aging (AAAs). Thirty-three (33) of the AAAs are local county-based organizations - non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and in accordance with all applicable policies and procedures.
✓	**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*:
	OLTL retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL also retains authority for all administrative decisions and supervision of non-governmental non-state agencies that conduct Waiver operational and administrative functions. Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates a component of the initial level of care assessment to determine clinical eligibility for waiver services to fifty-two (52) local Area Agencies on Aging (AAAs). Nineteen (19) of the AAAs are non-governmental non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and all applicable policies and procedures. OLTL has state level oversight authority over the enrollment function. Through a competitive procurement process, OLTL has a contract with one statewide Independent Enrollment Broker (IEB). The IEB facilitates eligibility determinations for multiple home and community-based waivers managed by OLTL. The IEB does not provide any ongoing direct services to the participant. The IEBs responsibilities are outlined above in Appendix A-3. OLTL also contracts with one Fiscal Employer/Agent (F/EA) to perform certain delegated functions for the successful operation of participant direction. The F/EA was also selected through a competitive procurement process. The F/EAs responsibilities are outlined above in Appendix A-3. Annual Re-evaluations – As noted above, the annual reevaluation for level of care is conducted by the local Service Coordination entities as described in Appendix C.
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and

	administrative functions.

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:

OLTL remains the ultimate authority for Waiver policies, rules, and regulations; and retains the ultimate authority on all administrative decisions. OLTL retains the responsibility for supervision and assessment of the performance of AAAs and other contracted entities. OLTL provides information and technical assistance to AAAs and Service Coordination entities through the Long-Term Living Training Institute, targeted technical assistance, and upon request.

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:

OLTL has undertaken a number of efforts through work with CMS on a Corrective Action plan, to strengthen the methods for overseeing entities performing administrative elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring.

OLTL oversees and monitors the performance of the local Area Agencies on Aging in conducting the initial level of care assessments for potential waiver enrollees. The OLTL Quality Management Efficiency Teams (QMETs) conduct onsite biennial operational reviews of each AAA to ensure that each function delegated to the AAAs is being performed in accordance with all OLTL requirements including the Waiver assurances and the Title XIX Medicaid Waiver Grant Agreement. For more information on the QMET structure, please refer to Appendix C, Quality Section on discovery and remediation.

Any AAA that exhibits noncompliance in any area will receive a Statement of Findings. The AAA is required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the AAA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. The AAA is expected to implement the approved CAP. If the AAA does not develop a satisfactory CAP, regulation permits OLTL to draft a CAP and require the AAA to implement the OLTL drafted CAP. Through a follow-up onsite review, OLTL validates that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence.

OLTL also aggregates information on findings from the AAAs to ascertain trends in non-compliance areas. Data is presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to reverse negative trends. Strategies include issuing or re-issuing instructions to the AAA community regarding performance obligations, implementing or revising training for AAAs on their responsibilities, or recommending contract revisions.

Much like its monitoring of the AAAs, OLTL oversees the contractual obligations of the Fiscal/Employer Agent (F/EA). QMETs conduct an onsite annual operational review of the contracted F/EA to ensure that all required functions are performed in accordance with all OLTL requirements including the Waiver assurances and the F/EA contract. These requirements include, but are not

limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In addition to the annual onsite operational review, there is significant oversight conducted on a monthly basis. The contract requires the F/EA to provide OLTL with monthly utilization reports, quarterly and annual status reports, as well as problem identification reports; these reports cover activities performed and issues encountered during the reporting period. OLTL will utilize these reports to monitor performance to ensure services are being delivered according to the contract.

If the F/EA exhibits noncompliance in any area of the waiver or contract, it will receive a Statement of Findings. The F/EA is required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. The F/EA is expected to implement the approved CAP. If the F/EA does not develop a satisfactory CAP, OLTL will draft a CAP and require the F/EA to implement the OLTL drafted CAP. A satisfactory CAP requires the provider to resolve the finding in a reasonable amount of time given the resources available. OLTL reviews the CAP to ensure the provider's plan to resolve the finding is both timely and complete. Through a follow-up onsite review, OLTL validates that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence.

F/EA findings are also presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to improve F/EA performance. Strategies include issuing or re-issuing instructions to the F/EA regarding performance obligations, implementing or revising training for the F/EA, participants or participant's workers on their responsibilities, or recommending contract revisions.

The Office of Long Term Living oversees the performance of the enrollment function which has been delegated to the Independent Enrollment Broker. The Independent Enrollment Broker is monitored annually on contracted performance measures. In addition to the annual contract monitoring, OLTL oversees ongoing operation through IEB performance on contracted performance measures that are collected monthly from the IEB and provided to the contract administrator and the Metrics and Analytics Division within the office of the Chief of Staff. Performance measures include sufficient staff to ensure calls are answered by a live person, at least 95% of the time, and the average phone wait time is less than 60 seconds for 100% of the calls. Other measures ensure timeliness of specific tasks such as conducting initial visits within seven days and forwarding information to the chosen Service Coordination Entity within two days. Systems information is contained in the contractor's Datamart database and it is loaded to OLTL to validate reports. If the Independent Enrollment Broker fails to meet established performance measure standards it must respond to the findings and remediate areas of non-compliance. If the Independent Enrollment Broker fails to remediate non-compliance it can result in adverse action against the contracted entity, including contract termination.

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 an administrative 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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	✓	☐	✓	☐
Waiver enrollment managed against approved limits	✓	☐	☐	☐
Waiver expenditures managed against approved levels	✓	☐	☐	☐
Level of care evaluation	✓	☐	✓	✓
Review of Participant service plans	✓	☐	☐	☐
Prior authorization of waiver services	✓	☐	☐	☐
Utilization management	✓	☐	✓	☐
Qualified provider enrollment	✓	☐	☐	☐
Execution of Medicaid provider agreements	✓	☐	✓	☐
Establishment of a statewide rate methodology	✓	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	✓	☐	☐	☐
Quality assurance and quality improvement activities	✓	☐	✓	☐

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through Age –	No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	●	**Aged or Disabled or Both – General** *(check each that applies)*			
		☐ Aged (age 65 and older)			☐

	☐	Disabled (Physical) (under age 65)			
	☐	Disabled (Other) (under age 65)			
	○	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	✓	Developmental Disability	18	59	☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA Waiver. Applicants age 60 and older will be referred to the Aging waiver.

Waiver services are limited to individuals with developmental disabilities, and who meet all of the following conditions:

1. Individuals who have a developmental disability (but do not have a primary diagnosis of either mental retardation or a major mental illness), who reside in a nursing facility, the community or an ICF/ORC, but who have been assessed to require services at the level of an ICF/ORC;
2. The disability manifested prior to the age of 22;
3. The disability is likely to continue indefinitely;
4. The disability results in three or more substantial functional limitations in major life activity: self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living.

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*):
	Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA Waiver.

Appendix B-2: Individual Cost Limit

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
○	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: $
	The dollar amount *(select one)*:
○	Is adjusted each year that the waiver is in effect by applying the following 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: %
○	Other – *Specify:*

State:	
Effective Date	

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-3: Number of Individuals Served

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	1694
Year 2	1694
Year 3	1694
Year 4 (renewal only)	1694
Year 5 (renewal only)	1694

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	0
Year 2	1586
Year 3	1586
Year 4 (renewal only)	1586
Year 5 (renewal only)	1586

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). For each purpose, describe how the amount of reserved capacity was determined:
	Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the OBRA Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the OBRA Waiver. Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.	
	Capacity Reserved	Capacity Reserved
Year 1	23	
Year 2	23	
Year 3	23	
Year 4 (renewal only)	23	
Year 5 (renewal only)	23	

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:

All individuals that are eligible for the waiver will be served. In the event of a waiting list for waiver services, the following entry criteria will be used:

1. Individuals who are currently receiving Medical Assistance in an institutional placement and need waiver services to transition into the community.

2. Individuals who are at risk of an institutional placement, which is defined as individuals who currently reside in the community and are at imminent risk of facility placement within 24-72 hours or less.

3. Individuals who are in the community but can wait more than 72 hours for home and community-based services.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. Waiver Years Subject to Phase-In/Phase-Out Schedule *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

●	§1634 State
○	SSI Criteria State
○	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

○	Yes
●	No

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
☐	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 the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	All other mandatory and optional groups under the State Plan are included.		
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be*			

completed				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
●	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
	●	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:		
		✓	A special income level equal to (select one):	
			●	300% of the SSI Federal Benefit Rate (FBR)
			○	% of FBR, which is lower than 300% (42 CFR §435.236)
			○	$ which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
		☐	Medically needy without spend down 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%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

Appendix B-5: Post-Eligibility Treatment of Income

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

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

●	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	●	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). 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-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. 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. <u>Allowance for the needs of the waiver participant</u> (*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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
●	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
●	Not applicable *(see instructions)*		

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The following standard under 42 CFR §435.121			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:			
○	Not applicable *(see instructions)*			

iii. <u>Allowance for the family</u> *(select one)*	
○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and *§*1634 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. <u>Allowance for the needs of the waiver participant</u> (*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)
		○	% of the FBR, which is less than 300%
		○	$ which is less than 300%.
	○	% of the Federal poverty level	
	○	Other standard included under the State Plan (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	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 the amount of the allowance:		
	○	SSI standard	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount: $	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> (*select one*):

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other *(specify)*:		

○	Not applicable *(see instructions)*

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (*specify):*			

ii. <u>Allowance for the spouse only</u> (*select one*):

○	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 the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
●	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	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 section 1902(r)(1) of the Act:			
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 checked.*		
○	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-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 waiver 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 *(insert number):*	
	2	
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*):
	The Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. In addition a physician (M.D or D.O) completes a level of care recommendation. Service Coordinators, employed by MA enrolled Service Coordination Agencies, conduct the annual reevaluations for participants that are already enrolled in the waiver. Service Coordinators also conduct reevaluations more frequently, if needed.

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:

AAA Assessors 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. One year experience in the AAA system may be substituted for one year assessment experience.

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.

The complete qualifications of the AAA Case Managers are located at the Department of Aging website at http://www.aging.state.pa.us; click on Aging Program Directives link then Home and Community Based Services Procedural Manual.

Physicians
Physicians are licensed through the Pennsylvania Department of State under the following regulations:

- Chapter 17 State Board of Medicine – Medical Doctors
- Chapter 25 State Board of Osteopathic Medicine

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.

Per 55 PA Code, Chapter 6210, an individual requires services at the level of an Intermediate Care Facility for Persons with an Other Related Condition (ICF/ORC) when they meet the following criteria:

1. Requires active treatment;
2. Has a diagnosis of another related condition; and
3. Has been recommended for an ICF/ORC level of care based on a medical evaluation.

The individual's physician certifies the ICF/ORC level of care with a physician's prescription. The local Area Agency on Aging (AAA) uses the Level of Care Assessment tool (LOCA), to determine the individual's disability, age of on-set and functional limitations.

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

●	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Initial Level of Care Evaluation:
The Office of Long-Term Living (OLTL) uses the following process to determine an individual's initial level of care:

- The participant first applies for OBRA Waiver services through the Independent Enrollment Broker. The role of the independent enrollment broker is to facilitate and support the participant through the enrollment process including the level of care evaluation. The enrollment broker follows the status of the level of care determination process and assists with any required communication between the participant, the participant's physician, and the AAA.

- The enrollment broker assists the participant with obtaining a completed prescription from the participant's physician (M.D. or D.O.)

- A physician completes a prescription form indicating the physician's level of care recommendation.

- The enrollment broker forwards the physician's prescription along with a request for a level of care assessment to the local Area Agency on Aging (AAA).

- The AAA assessor visits the participant and uses the "Level of Care Assessment" (LOCA) form to identify information regarding the participant's medical status, recent hospitalizations, and functional abilities (ADLs and IADLs). Through the level of care assessment, the AAA assessor identifies and determines whether the individual has a developmental disability, whether the individual has at least three functional limitations and recommends the need for active treatment.

- The AAA is responsible for making the final level of care evaluation decision.

Annual Reevaluation:
OLTL uses the following process for the annual reevaluation of current participants:

- The participant's Service Coordination agency is responsible for completion of the annual reevaluation of the level of care.

- The Service Coordinator completes the annual reevaluation by visiting the participant and completing a Reassessment Summary Form.

- The Reassessment Summary form mirrors the information collected in the LOCA, including information on medical changes, recent hospitalizations, changes in functional status (ADLs and IADLs), and the continued need for active treatment.

- The information collected on the Reassessment form is compared to the information collected in the individual's previous evaluation or reevaluation.

- The Service Coordination Agency is responsible for making the final level of care reevaluation eligibility decision.

OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations. This is referenced in the Quality Improvement section.

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*):

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. The qualifications of individuals who perform reevaluations are *(specify)*:
	Have a Bachelor's Degree in social work, social science, or related field of human service, such as psychology, and one year of case management experience, or at least six months of professional experience and at least six months as a Home and Community Based Services waiver/program participant; or Have an Associate's Degree in social work, social science, or related field of human

	service, such as psychology, and two years of case management experience, or at least one year of professional experience and at least on year as a Home and Community Based Services waiver/program participant; or Have successfully completed 12 credit hours of human services course work from an accredited college or university, and at least four years of professional experience, or at least two years of professional experience and at least two years as a Home and Community Based Services waiver/program participant. Must have required training, including at a minimum: Office of Long-Term Living's (OLTL) Service Coordination Training. Each service coordinator will be required to have 40 hours of training during the first year of employment and 20 hours annually. Service Coordinator Supervisor must meet the same qualifications as the Service Coordinator including two years' experience as a Service Coordinator

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)*:

On an annual basis from the date the initial evaluation is completed the Service Coordinator will meet with the participant in their home to reassess the participant's need for waiver services and complete the Reassessment Summary Form. One month prior, the Service Coordinator will be alerted to the anniversary certification date through an automated notice from the Home and Community Services Information System (HCSIS). In addition, each Service Coordination agency maintains its own tickler system to complete timely reevaluations and maintain consistency in service.

After the reevaluation is completed, the Service Coordinator enters the information in a service note in HCSIS. The reevaluation information is maintained in the participant's file which is subject for review during OLTL annual monitoring visits.

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:

Home and Community Services Information System (HCSIS)
Service Coordinators maintain copies of evaluations in participant's record located at the Service Coordination agency.

Appendix 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).

PARTICIPANT FREEDOM OF CHOICE

Participants have the right to freedom of choice of providers and of choice of feasible alternatives.

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for OBRA Waiver services and the participant is determined to likely need the Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) level of care, the individual will be:

- Informed by the independent enrollment broker of any feasible service delivery alternatives available under the waiver; and,
- Given the choice of receiving institutional (ICF/ORC) services, waiver services, or no services

Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the independent enrollment broker and ongoing by their Service Coordinator, of their right to choose between receiving home and community-based waiver services, ICF/ORC services, to remain in their present program, or receiving no services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form.

The independent enrollment broker is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination agencies, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form. In addition, the enrollment broker is responsible for educating participants of their right to choose from any qualified provider, that they are not required to receive service coordination and service plan services from the same provider and that they have the right to change providers at any time. The enrollment broker will give each participant information about the Services and Supports Directory – a listing of all enrolled providers, which is maintained on HCSIS. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service

Coordination agency. OLTL monitors participant receipt of the forms as part of its bi-annual provider reviews.

The Service Coordination agency is responsible for ensuring participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination agency is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination agency. OLTL monitors participant receipt of the forms as part of its bi-annual provider reviews.

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.

Service Coordinators maintain copies of the choice forms in the participant's record located at the Service Coordination agency.

Appendix B-8: Access to Services by Limited English Proficient 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):

Waiver documentation is made available in different language upon request. If a specific language or interpreter is required, the Service Coordinators are instructed to call the Office of Long-Term Living. Language assistance will be provided without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing.

Each provider is required to have and implement policies and procedures for ensuring language assistance service to people who have limited proficiency in English.

Appendix C: Participant Services

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☑	Service Coordination
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☑	Personal Assistance Services
Adult Day Health	☑	Adult Daily Living
Habilitation	☐	
Residential Habilitation	☑	
Day Habilitation	☑	Structured Day Habilitation
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☑	
Supported Employment	☑	
Education	☐	
Respite	☑	

Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Personal Emergency Response System (PERS)
b.	
c.	Community Integration
d.	Community Transition Services
e.	Non-Medical Transportation
f.	Therapeutic and Counseling Services
g.	Home Adaptations
h.	Vehicle Modifications
i.	Assistive Technology

Extended State Plan Services *(select one)*	
○	Not applicable
●	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Home Health – Home Health Aide
b.	Home Health - Nursing
c.	Home Health – Physical Therapy
d	Home Health – Occupational Therapy
e	Home Health – Speech and Language Therapy
f	Specialized Medical Equipment and Supplies

Supports for Participant Direction *(check each that applies))*	
✓	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
✓	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.

○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	✓	Service Coordination
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		
c.		

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants *(check each that applies)*:

✓	As a waiver service defined in Appendix C-3 (*do not complete 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. NOTE: Pursuant to CMS-2237-IFC* this selection is no longer available for 1915(c) waivers.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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:

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)*:

●	**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 checks are required for all support service workers and must be conducted in accordance with 55 PA Code, Chapter 52, Sections 52.19 and 52.20. Individuals choosing to self-direct their services have the right to employ a worker regardless of the outcome of the background check. Support service workers who are employed by waiver participants must have criminal history clearances completed prior to hire, facilitated through the FEA as described below, so that participants can make an informed decision on whether to employ a worker who has a criminal record. 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; results are typically available within 1-2 business days. A Federal Bureau of Investigation (FBI) federal criminal history record is required for applicants who have resided in Pennsylvania for less than two years. The home care/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, as well as the results of the background check. The Fiscal Employer/Agent (F/EA) is responsible for securing criminal history background checks for prospective support service workers prior to hiring workers. The cost of conducting criminal history background checks is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to 1) document that the criminal history background check was conducted, and 2) notify individuals of the results of the background check, and 3) document the individual's decision to employ a support service worker with a criminal record and their acceptance of responsibility for their decision. OLTL reviews provider personnel records as part of the biennial monitoring to ensure that criminal history checks are conducted and documented as referenced in the Quality Improvement section in this Appendix. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

●	**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):
	The Department of Human Services maintains a child abuse registry of individuals who have been named as a perpetrator of founded or indicated child abuse. A similar registry is not maintained for individuals who have been named as a perpetrator of founded or indicated elder abuse; these results are reported on the criminal history background check. 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, DHS-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. Support service workers who are employed by waiver participants must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse. The home care/personal assistance 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. In the interim of securing the written results of child abuse clearances, the provider of service will obtain written certification from the employee which confirms that the employee has not, within five (5) years immediately preceding the date of employment with the waiver program, been named on a central child abuse registry as being a perpetrator of founded or indicated child abuse. The F/EA is responsible for securing child abuse clearances for prospective support service workers. The cost of conducting child abuse clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the child abuse clearance was conducted. OLTL reviews provider personnel records as part of the biennial monitoring to ensure that child abuse clearances are conducted and documented as referenced in the Quality Improvement section below. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.
○	**No**. The State does not conduct abuse registry screening.

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. *Do not complete Items C-2-c.i – c.iii.*
●	**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). *Complete Items C-2-c.i –c.iii.*

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

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Personal Care Home	Residential Habilitation	8
		8

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

Residential Habilitation services may be provided to participants in Personal Care Homes, which must demonstrate a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining areas, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Personal Care Homes are licensed under Title 55 PA Code 2600and are designed to provide safe, comfortable and supportive residential settings for adults. Residents who live in personal care homes receive the encouragement and assistance they need to develop and maintain maximum independence and self-determination. Bedrooms in personal care homes should be individualized and show signs of personalization such as photos, bedding, art or other decorations selected by the resident. The kitchen may not contain signs of institutionalization like locks on cabinets. Furniture cannot be uniform or institutional in nature. The bathrooms are personalized with towels and toiletries that reflect the participant's personal preferences. The personal care home is decorated with personal photos, arts, and other decorations that reflect the participant's tastes living in the home.
Licensed settings serving individuals enrolled in the OBRA waiver may not exceed a licensed capacity of more than 8 unrelated individuals. Services must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Personal Care Home	Facility Type	Facility Type	Facility Type
Admission policies	✓	☐	☐	☐
Physical environment	✓	☐	☐	☐
Sanitation	✓	☐	☐	☐
Safety	✓	☐	☐	☐
Staff : resident ratios	✓	☐	☐	☐
Staff training and qualifications	✓	☐	☐	☐
Staff supervision	✓	☐	☐	☐
Resident rights	✓	☐	☐	☐
Medication administration	✓	☐	☐	☐

Use of restrictive interventions	✓	☐	☐	☐
Incident reporting	✓	☐	☐	☐
Provision of or arrangement for necessary health services	✓	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Family members can provide Personal Assistance Services; however, the following exclusions apply: • The OBRA Waiver will not pay for services furnished by the participant's spouse.

	• The OBRA Waiver will not pay for services furnished by a legal guardian. • The OBRA Waiver will not pay for services furnished by a Power of Attorney (POA). . • The OBRA Waiver will not pay for services furnished by a Representative Payee. Aside from the exceptions noted above, there are no restrictions on the types of family members who may provide Personal Assistance Services. Family members who provide Personal Assistance Services must meet the same provider qualification standards as Support Services workers who provide Personal Assistance Services to non-relatives. Individual service plans for individuals who receive more than 40 hours per week of services from one individual (family member or non-family member) will be reviewed and approved by OLTL. Service Coordinators will monitor the provision of services in accordance with OLTL established protocols. OLTL will review participant records as part of the biennial monitoring to ensure that Service Coordinators have monitored the provision of services and documented their monitoring activities in accordance with OLTL protocols. Family members who provide Personal Assistance Services, like all providers, must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews authorized billable units through the Home and Community Based Services Information System (HCSIS). Reimbursement for services rendered is generated through the Provider Reimbursement Operations Management Information System (PROMISe). Service delivery is monitored electronically through HCSIS and PROMISe to provide reimbursement for services approved in the participant's ISP. The F/EA will not pay for services that are not documented as necessary on the ISP.
○	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers have the opportunity to enroll as waiver providers at any time. 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 DHS website

http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm

As a condition of participation in the OBRA waiver, potential providers must meet the requirements set forth in 55PA Code, Chapter 52, as well as other applicable regulatory provisions. OLTL maintains responsibility for ensuring providers meet the approved provider qualifications, including certification and licensure, as referenced in the Quality Improvement section below. In addition, OLTL is responsible for enrolling qualified providers as a Medicaid waiver provider.

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

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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; and, (f) how participants are notified of the amount of the limit.

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

OBRAWAIVER SERVICE DEFINITIONS

Appendix C-3: Waiver Services Specifications

State:	
Effective Date	

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Personal Assistance Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Personal Assistance Services primarily provide hands-on assistance to participants that are necessary, as specified in the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

This service will be provided to meet the participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the participant's service plan.

Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include:

- Care to assist with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the participant to perform a task, and providing supervision to assist a participant who cannot be safely left alone.
- Health maintenance activities 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 and permitted under applicable State requirements.
- Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the participant.
-
- Assistance and implementation of prescribed therapies.
- 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.

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living:

- Activities that are incidental to the delivery of Personal Assistance to assure the health, welfare and safety of the participant such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not

comprise the majority of the service.

- Services to accompany the participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.

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

Personal Assistance Services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

Costs incurred by the personal assistance workers while accompanying the participant into the community are not reimbursable under the waiver as Personal Assistance Services. The transportation costs associated with the provision of Personal Assistance outside the participant's home must be billed separately and may not be included in the scope of Personal Assistance. Personal Assistance workers may furnish and bill separately for transportation provided that they meet the state's provider qualifications for transportation services, whether medical transportation under the State plan or non-medical transportation under the waiver.

Activities that are incidental to the delivery of Personal Assistance 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.

Personal Assistance Services cannot be provided simultaneously with Home Health Care Aide Services, Residential Habilitation, or Respite.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Support Service Worker		**Home Care Agency**	

Specify whether the service may be provided by *(check each that applies):*		Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:

State:	
Effective Date	

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Agency	Licensed by the PA Department of Health, per 28 PA Code Part IV, Subpart H, Chapter 611 (Home Care Agencies and Home Care Registries), under Act 69	N/A	Agency: • Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, and policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; Have Commercial General Liability Insurance • Have Professional Liability Errors and Omissions Insurance • Have Workers' Compensation Insurance in accordance with State statute and in accordance with Department policies • Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs; and • Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21. • Individuals working for or contracted with agencies must meet the following standards: Be 18 years of age or older; • Possess basic math, reading, and writing skills; • Complete training or demonstrate competency by passing a competency test as outlined under Title 28, Part IV Subpart H of the Health Care Facilities Act Have the required skills to perform

			services as specified in the participant's service plan; • Complete any necessary pre/in-service training related to the participant's service plan; • Agree to carry-out outcomes included in the participant's service plan; • Possess a valid Social Security number; • Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Individual Support Service Worker	N/A	N/A	Support Service workers must: • Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Be 18 years of age or older;

			• Possess basic math, reading, and writing skills; • Possess a valid Social Security number; • Submit to a criminal records check; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); • Have the required skills to perform Personal Assistance Services as specified in the participant's service plan; • Complete any necessary pre/in-service training related to the participant's service plan; • Agree to carry-out outcomes included in the participant's service plan; and • 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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Agency	OLTL/PA Department of Health	At least every two years and more frequently when deemed necessary by the Department
Individual Support Service Worker	Fiscal Employer Agent/OLTL	At least every two years and more frequently when deemed necessary by the Department.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Community Transition Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The service must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure health, welfare and safety of the participant.

Community Transition Services may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

- Equipment, essential furnishings and initial supplies. Examples—e.g. household products, dishes, chairs, tables;
- Moving Expenses;
- Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement;
- Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating;
- Items for personal and environmental health and welfare (Examples –personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.)

The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii.

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

- Community Transition Services are furnished only to the extent that they are reasonable and necessary, as determined through the ISP development process; clearly identified in the service plan and the participant is unable to meet such expense; or when the service cannot be obtained from other resources

State:	
Effective Date	

- Expenditures may not include ongoing payment for rent or mortgage expenses.
- Community Transition Services do not include food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.
- Community Transition Services are limited to the purchase of the specific items to facilitate transition and not the supports or activities provided to obtain the items.
- Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.

This service does not cover those services available under Assistive Technology, Home Adaptations, Specialized Medical Equipment and Supplies, and Vehicle Modifications.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Independent Vendor		Transitional Service Provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transitional Service Provider			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; • Ensure that employees (direct,

			contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and • Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with all Department standards, regulations, policies and procedures related to provider qualifications; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Independent Vendor			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider

			qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and • Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA

			Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transitional Service Provider	OHCDS OLTL	OHCDS - Upon Purchase and Annually thereafter At least every two (2) years and more frequently when deemed necessary by the Department
Independent Vendor	OHCDS OLTL	OHCDS - Upon Purchase and Annually thereafter At least every two (2) years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Personal Emergency Response System (PERS)
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)**:**

PERS is an electronic device which enables waiver participants to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year.

PERS services are limited to those individuals who:

- Live alone.
- Are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances.
- Live with an individual that may be limited in their ability to access a telephone quickly when a participant has an emergency.
- Would otherwise require extensive in-person routine monitoring and assistance. Installation, repairs, monitoring and maintenance are included in this service.

The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii

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

This service is not covered in the State Plan. Participants can only receive PERS services when they meet eligibility criteria specified in accordance with Department standards, and the services are not covered under Medicare or other third-party resources.

The Service Coordinators must assure that coverage of services provided under a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance

with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization.

Installation is covered one time per residential site.

Standalone smoke detectors will not be billed under PERS.

PERS covers the actual cost of the service and does not include any additional administrative costs.

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Vendors of Personal Emergency Response Systems
				Home Health Agency
				Durable Medical Equipment and Supply Company

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendors of Personal Emergency Response Systems			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability

			insurance; • All PERS installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply, including any applicable business license; and • Organization must have capacity to provide 24-hour coverage by trained professionals, 365 days/year. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Home Health Agency	Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart G. Chapter 601 and Subpart A Chapter 51	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in

			Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Durable Medical Equipment and Supply Company			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation

			insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vendors of Personal Emergency Response Systems	OLTL/OHCDS	OHCDS - Upon Installation and Annually thereafter OLTL – At least every two (2) years and more frequently when deemed necessary by the Department
Home Health Agency	OLTL/OHCDS	OHCDS - Upon Installation and Annually thereafter OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Durable Medical Equipment and Supply Company	OLTL/OHCDS	OHCDS - Upon Installation and Annually thereafter OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Service Coordination
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Service Coordination identifies, coordinates and assists participants to gain access to needed waiver services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to participants and facilitating access, locating, coordinating and monitoring needed services and supports for waiver participants.

This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements, and as outlined in the participant's service plan.

In the performance of providing information to participants, the Service Coordinator will:

- Inform participants about the waiver, required needs assessments, the participant-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities.
- Inform participants on fair hearing rights and assist with fair hearing requests when needed and upon request.
-

In the performance of facilitating access to needed services and supports, the Service Coordinator will:

- Collect additional necessary information, including, at a minimum, participant preferences, strengths and goals to inform the development of the participant-centered service plan.
- Conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements.
- Assist the participant and his/her service planning team in identifying and choosing willing and qualified providers.
- Coordinate efforts and prompt the participant to ensure the completion of activities necessary to

maintain waiver eligibility.

In the performance of the coordinating function, the Service Coordinator will:

- Coordinate efforts in accordance with Department requirements and prompt the participant to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan.
- Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
  - Include people chosen by the participant for service plan meetings, review assessments, including discussion of needs, to gain understanding of the participant's preferences, suggestions for services and other activities key to ensure a participant-centered service plan.
  - Provide necessary information and support to ensure that the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
  - Be timely and occur at times and locations of convenience to the participant.
  - Reflect cultural considerations of the participant.
  - Include strategies for solving conflict or disagreement within the process.
  - Offer choices to the participant regarding the services and supports they receive and the providers who may render them.
  - Inform participants of the method to request updates to the service plan.
  - Ensure and document the participant's participation in the development of the service plan.
- Develop and update the service plan in accordance with Appendix D, based upon the standardized needs assessment and participant-centered planning process annually, or more frequently as needed.
- Explore coverage of services to address participant identified needs through other sources, including services provided under the State Plan, Medicare and/or private insurance or other community resources. These resources shall be used until the plan limitations have been reached or a determination of non-coverage has been established and prior to any service's inclusion in the service plan, in accordance with Department standards.
- Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the participant, including Health Choices care coordinators, to ensure seamless coordination between physical, behavioral and support services.
- Coordinate with providers and potential providers of services to ensure seamless service access and delivery.
- Coordinate with the participant's family, friends and other community members to cultivate the participant's natural support network, to the extent that the participant (adult) has provided permission for such coordination.

In the performance of the monitoring function, the Service Coordinator will:

- Ensure that services are furnished in accordance with the ISP.
- Ensure that services meet participant needs.

- Monitor the health, welfare and safety of the participant and service plan implementation through regular contacts (monitoring visits with the participant, paid and unpaid caregivers and others) at a minimum frequency as required by the Department.
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare and safety of the participant in accordance with Appendix G.
- Monitor the effectiveness of back-up plans.
- Review provider documentation of service provision and monitor participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes.
- Through the service plan monitoring process, solicit input from participant and/or family, as appropriate, related to satisfaction with services.
- Arrange for modifications in services and service delivery, as necessary, to address the needs of the participant, consistent with an assessment of need and Department requirements, and modify the service plan accordingly.
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and participant rights.
- Participate in any Department identified activities related to quality oversight.

Service Coordination includes functions necessary to facilitate community transition for participants who received Medicaid-funded institutional services (i.e. Nursing Facilities) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Service Coordination activities for participants leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community.

Service Coordination entities must use an information system as approved and required by the Department to maintain case records in accordance with Department requirements.

Services must be delivered in a manner that supports the participant's communication needs, including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

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

Service Coordination is limited to 144 units over a 12-month period. However, in order to meet the varying needs of individuals for service coordination services, this service limitation may be waived when reviewed and approved by OLTL.

The following activities are excluded from Service Coordination as a billable waiver service:

- Outreach or eligibility activities (other than transition services) before participant enrollment in the waiver.
- Travel time incurred by the Service Coordinator may not be billed as a discrete unit of service.
- Services that constitute the administration of another program such as protective services, parole and probation functions, legal services, and public guardianship.

- Representative payee functions.
- Other activities identified by the Department.

Service Coordination must be conflict free and may only be provided by agencies and individuals employed by agencies who are not:

- Related by blood or marriage to the participant or to any paid service provider of the participant
- Financially or legally responsible for the participant.
- Empowered to make financial or health-related decisions on behalf of the participant.
- Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant.
- Individuals employed by agencies paid to render direct or indirect services (as defined by the Department) to the participant, or an employee of an agency that is paid to render direct or indirect services to the participant.

Claims for costs incurred on behalf of participants transitioning from an institutional setting may only be paid after the transition to the community.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Service Coordination Entity

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Service Coordination Entity			Service Coordination Entities must: • Comply with 55 PA Code 1101 and have a waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Meet the conflict free requirements pursuant to 55 PA Code, Chapter

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			52, §52.28; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; • Comply with and meet all standards as applied through each phase of the standard, annual Department performed monitoring process; • Ensure 24-hour access to Service Coordination personnel (via direct employees or a contract) for response to emergency situations that are related to the Service Coordination service or other waiver services; • Sufficient professional staff to perform the needed assessment/reevaluation, service coordination and support activities; and • Registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. Service Coordinators must meet the following: •

			• Be at least 18 years of age; • Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service. Service Coordination Supervisors must meet the following: • Be at least 18 years of age; • Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Service Coordination Entity	**OLTL**	At least every two (2) years and more frequently when deemed necessary by the

		Department		
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Prevocational Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope):	

Prevocational services are services not available under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the individuals with Disabilities Education Act of 1973 [20 U.S.C. 1201 (16 and 17)]. Services are aimed at preparing an individual for paid or unpaid employment but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Prevocational services are provided to persons not expected to be able to join the work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

- Activities included in this service are not primarily directed at teaching skills, but at underlying goals directed at assisting the consumer towards greater independence, such as improving attention span and motor skills.
- When compensated, individuals are paid at less than 50 percent of the minimum wage.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services.

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

Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.

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

Provider Specifications				
Provider Category(s)	☐	Individual. List types:	X	Agency. List the types of agencies:
				Vocational Facility

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(check one or both):		

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vocational Facility	55 PA Code Chapter 2390		• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs Individuals working for or contracted with agencies must meet the following

			standards: • Be at least 18 years of age; • Possess a valid Social Security number; • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vocational Facility	PA Department of Public Welfare OLTL	DPW – Annually OLTL – At least every two years and more frequently when deemed necessary by the Department.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Supported Employment
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Supported Employment Services are paid employment services for persons for whom competitive employment at or above the minimum wage is unlikely, and who because of their disability need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training of the individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
When Supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; • Payments that are passed through to users of Supported employment programs; or • Payments for training that is not directly related to an individual's Supported employment program. Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.	

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This service may not exceed eight (8) hours per day. The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Supported Employment Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Employment Agency			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; • Have Professional Liability Errors and Omissions Insurance; • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet

			the unique needs of the participant; for example, communication, mobility and behavioral needs Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Have a high school diploma or GED and six months of paid or volunteer experience in working with people with physical disabilities and/or older adults • Have the required skills to perform the Supported Employment services specified in the participant's service plan • Have completed a service specific training program related to goals in the participant's service plan • Possess a valid Social Security number; • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is

			necessary to provide the service

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supported Employment Agency	OLTL	Every two years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Home Health Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. <u>Home Health Aide Services</u>

Home Health Aide services are direct services prescribed by a physician in addition to any services furnished under the State Plan that are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The physician's order must be obtained every sixty (60) days for continuation of service. The home health aide provider is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan.

Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist

2. <u>Nursing Services</u>

Nursing services are direct services prescribed by a physician, in addition to any services under the State Plan, that are needed by the participant, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Nursing services must be performed by a Registered Nurse or Licensed Practical Nurse. 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."

Nursing 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 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. Nursing services are individual, and can be continuous, intermittent, or short-term based on individual's assessed need.

- Short-term or Intermittent Nursing — Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a service plan year and are over and above services available to the participant through the State Plan
- Long-term or Continuous Nursing — Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per service plan year, are provided on a regular basis and are over and above services available to the participant through the State Plan

The nurse is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan

3. <u>Physical Therapy</u>

Physical Therapy services are direct services prescribed by a physician, in addition to any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Physical Therapy services must address an assessed need as documented in the participant's service plan. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Physical Therapy services authorized in the service plan.

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

4. <u>Occupational Therapy</u>

Occupational Therapy services are direct services prescribed by a physician, in addition to any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Occupational Therapy services must address an assessed need documented in the participant's service plan. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Occupational Therapy services authorized in the service plan.

Occupational Therapy can be provided by a licensed occupational therapist or occupational therapy assistant in accordance with applicable State standards. The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows, "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

5. <u>Speech and Language Therapy</u>

Speech and Language Therapy services are direct services prescribed by a physician, in addition to

any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Speech and Language Therapy Services must address an assessed need as documented in the participant's service plan. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Speech and Language Therapy services authorized in the service plan.

Speech and Language Therapy services are provided by a licensed and American Speech Language Hearing Associate, certified speech-language pathologist and speech therapist assistants in accordance with applicable State standards including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of augmentative and alternative communication strategies.

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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

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

Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.

Home Health Care Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

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

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

documented in the participant's service plan.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Physical Therapist or Assistant		**Home Health Agency**	
	Occupational Therapist or Assistant		**Out-Patient or Community-Based Rehabilitation Agency**	
	Speech Therapist			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age;

			• Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); • Be supervised by a registered nurse; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).
Out-Patient or Community-Based Rehabilitation Agency	Licensed by the PA Department of Health, per 28 PA Code	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code

			Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Must hold an appropriate active license in the State of Pennsylvania; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is

			necessary to provide the service.
Physical Therapist or Assistant (agency affiliated or individual)	Licensed under PA Department of State, per 49 PA Code Chapter 40, including 40.53 pertaining to delegation of duties and use of assistants (Physical Therapy Licensing Board)	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Occupational Therapist or Assistant (agency affiliated or individual)	Licensed under the PA Department of State, per 49 PA Code Chapter 42, including 42.22	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider

	pertaining to assistants (Occupational Therapy and Education Licensing Board)		qualifications, including 55 PA Code Chapter 52; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Speech Therapist (agency affiliated or individual)	Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania;

			• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	OLTL/PA Department of Health	At least every two (2) years and more frequently when deemed necessary by the Department
Out-Patient or Community-Based Rehabilitation Agency	OLTL/PA Department of Health	At least every two (2) years and more frequently when deemed necessary by the Department
Physical Therapist or Assistant	PA Department of State Physical Therapy Licensing Board	At least every two (2) years and more frequently when deemed necessary by the Department
Occupational Therapist or Assistant	PA Department of State Occupational Therapy and Education Licensing Board	At least every two (2) years and more frequently when deemed necessary by the Department
Speech Therapist	PA Department of State Language and Hearing Examiner's Board	At least every two (2) years and more frequently when deemed necessary by the

			Department	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	
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)**:**	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
			•
			•
			•

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

State:	
Effective Date	

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to the Centers for Medicare and Medicaid Services upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Assistive Technology
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the participant, as specified in the participant's individual service plan (ISP) and determined necessary in accordance with the participant's assessment. The service is intended to ensure the health, welfare and safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities.

Assistive Technology includes supports to a participant in the selection, acquisition or use of an Assistive Technology device. Training to utilize adaptations, modifications and devices is included in the purchase, as applicable. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.

Assistive Technology is limited to:

- Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for participants
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings
- Training or technical assistance for the participant, paid caregiver and unpaid caregiver
- An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment
- Extended warranties

State:	
Effective Date	

- Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist participants with a need identified through the evaluation described below

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

If the participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service.

The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.

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

Assistive Technology services may only be funded through the waiver when the services are not covered by the State Plan, EPSDT or a responsible third-party, such as Medicare or private insurance. Supports Coordinators must assure that coverage of services provided under the State Plan, EPSDT or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

This service excludes those items that are not of direct medical or remedial benefit to the participant. Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the OLTL when an independent evaluation specifies that the item is primarily used for a participant's specific therapeutic purpose and serves as a less costly alternative than other suitable devices and alternative methods.

The following are specifically excluded from this service definition

- Recreational items
- Items that do not provide direct remedial benefit or improve the participant's ability to communicate with others

Depending on the type of technology, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; physical therapist; or other certified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Independent evaluations conducted by a certified professional as defined in the provider qualifications for this service , not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service..

This service does not include TeleCare services. Data plans are excluded from coverage.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Contractor		Durable Medical Equipment	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment		Drug and Device Registration with the PA Dept. of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.	• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs • Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement • Meet State regulations under 55

			PA Code 1123 regarding participation for medical supplies • Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professional must be a graduate of a Department approved Rehabilitative Sciences program that is Certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or a Rehabilitative Sciences degree with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professional must be a graduate of a Department approved Rehabilitative Sciences program that is Certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or a Rehabilitative Sciences degree with at least one year in evaluation and assessment of assistive technology needs for

			individuals with disabilities. • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
Contractor			• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (A company that the provider secures the item(s) from can be located anywhere) • Adhere to all applicable local and State codes • Have Commercial General Liability Insurance • Have Workers Compensation Insurance, in accordance with State statute
			•

State:	
Effective Date	

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Durable Medical Equipment	OHCDS or OLTL	At time of service
Contractor	OHCDS	At time of service

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to the Centers for Medicare and Medicaid Services upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home Adaptations
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Home Adaptations are physical adaptations to the private residence of the participant, as specified in the participant's individual service plan (ISP) and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. This includes personal egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home.

Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations.

Adaptations to a household are limited to the following:

- Ramps from street, sidewalk or house
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the participant
- Vertical lifts
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving a participant with a disability from one location to another
- Handrails and grab-bars in and around the home
- Accessible alerting systems for smoke/fire/carbon monoxide for participants with sensory impairments
- Outside railing to safely access the home
- Widened doorways, landings and hallways
- Swing-clear and expandable offset door hinges

State:	
Effective Date	

- Flush entries and leveled thresholds
- Slip resistant flooring
- Kitchen counter, sink and other cabinet modifications (including brackets for appliances)
- Bathroom adaptations for bathing, showering, toileting and personal care needs
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely
- Raised electrical switches and sockets
- Other adaptations, subject to OLTL approval, to address specific assessed needs as identified in the service plan

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

Home Adaptations shall meet standards of manufacture, design and installation.

Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs.

The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.

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

Home Adaptations may only be funded through the waiver when the services are not covered by the State Plan, EPDST or a responsible third-party, such as Medicare or private insurance. Supports Coordinators must assure that coverage of services provided under the State Plan, EPSDT or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with OLTL requirements must be maintained in the participant's file by the Service Coordinator and updated with each authorization.

This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; physical therapist; or other qualified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home Adaptations included in the service plan and begun while the person was institutionalized are not considered complete and may not be billed until the date the participant leaves the institution and enters the waiver.

Building a new room is excluded. Specialized Medical Equipment and Supplies is excluded.

Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom.

Materials and equipment must be based on the participant's need as documented in the ISP.

State:	
Effective Date	

Rented property adaptations must meet the following:

- there is a reasonable expectation that the participant will continue to live in the home;
- written permission is secured from the property owner for the adaptation;
- the landlord will not increase the rent because of the adaptation.
- there is no expectation that waiver funds will be used to return the home to its original state.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service may not be included on the same service plan as Residential Habilitation.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Contractor		Contractor	
			Durable Medical Equipment	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contractor	Contractor's license for the State of Pennsylvania or a state contiguous to Pennsylvania, if required by trade.		• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation

State:	
Effective Date	

			insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable. • All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply • Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license • Compliance with the Pennsylvania Home Improvement Consumer Protection Act and other applicable standards Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to,

			communication, mobility and behavioral needs, if applicable. • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
Durable Medical Equipment		Drug and Device Registration with the PA Dept. of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.	• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable. • All Home Adaptations installed

			shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply • Organizations must have capacity to provide 24-hour coverage by trained professionals, 365 days/year Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Be a Licensed Contractor • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Contractor	OHCDS or OLTL	At least every two (2) years

State:	
Effective Date	

		and more frequently when deemed necessary by the Department
Durable Medical Equipment	OHCDS or OLTL	At least every two (2) years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to the Centers for Medicare and Medicaid Services upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Specialized Medical Equipment and Supplies
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant's disability. These services or items are necessary to ensure health, welfare and safety of the participant and enable the participant to function in the home and community with greater independence. This service is intended to enable participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the participant's service plan and determined necessary in accordance with the participant's assessment.

Specialized Medical Equipment and Supplies includes:

- 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.
- Equipment repair and maintenance, unless covered by the manufacturer warranty
- Items that exceed the limits set for Medicaid State plan covered services
- Rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment and Supplies

Non-Covered Items:

- All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
- Items covered under third party payer liability
- Items that do not provide direct medical or remedial benefit to the participant and/or

are not directly related to a participant's disability

- Food, food supplements, food substitutes (including formulas), and thickening agents;
- Eyeglasses, frames, and lenses;
- Dentures
- Hearing Aids
- Any item labeled as experimental that has been denied by Medicare and/or Medicaid
- Recreational or exercise equipment and adaptive devices for such

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

If the participant receives Speech, Occupational, or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Specialized Medical Equipment and Supplies, the Specialized Medical Equipment and Supplies must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service.

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

Specialized Medical Equipment and Supplies may only be funded through the waiver when the services are not covered by the State Plan, EPSDT or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan, EPSDT or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; physical therapist; or other qualified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services offered through the waiver; Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate.

Specialized Medical Equipment and Supplies exclude Assistive Technology.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Provider Specifications				
Provider Category(s)	☐	Individual. List types:	X	Agency. List the types of agencies:
				Durable Medical Equipment

State:	
Effective Date	

(check one or both):		Pharmacy	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐ Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment		Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25	• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs • Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement • Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies Individuals working for or contracted with agencies must meet the

			following standards: • Be at least 18 years of age • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
Pharmacy	Bureau of Professional and Occupational Affairs – Department of State	Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25	• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the

			participant; for example, communication, mobility and behavioral needs • Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Durable Medical Equipment	OLTL	At time of service
Pharmacy	OLTL	At time of service

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to the Centers for Medicare and Medicaid Services upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Vehicle Modifications
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community. The following are specifically excluded:

- Modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant
- Purchase or lease of a vehicle with or without existing adaptations
- Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications

The waiver cannot be used to purchase vehicles for participants, their families or legal guardians. Vehicle Modifications funded through the waiver are limited to the following:

- Vehicular lifts
- Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle
- Interior alterations to seats, head and leg rests and belts
- Customized devices necessary for the participant to be transported safely in the community, including driver control devices
- Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions
- Raising the roof or lowering the floor to accommodate wheelchairs
- The vehicle must be less than 5 years old, and have less than 50,000 miles for vehicle

State:	
Effective Date	

modification requests over $3,000

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

The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.

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

A vehicle is required to have passed all applicable State standards.

This service does not include, but requires, an independent evaluation. Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; physical therapist; or other qualified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate.

The vehicle that is modified may be owned by the participant, a family member with whom the participant lives, or a non-relative who provides primary support to the participant and is not a paid provider agency of services. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Provider Specifications

Provider Category(s) *(check one or both)*:	[]	Individual. List types:	X	Agency. List the types of agencies:
				Vehicle Modifications Contractor

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vehicle Modifications Contractor		Quality Assurance Program (QAP) Accreditation by the National Mobility Equipment Dealers Association	• Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania

State:	
Effective Date	

		(NMEDA).	• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs • Adhere to all applicable local and State codes Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance (as per 23 PA C.S. Chapter 63) • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:

State:	
Effective Date	

Vehicle Modifications Contractor	OHCDS or OLTL		At least every two (2) years and more frequently when deemed necessary by the Department	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Respite Services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable. In-home Respite Services cannot be provided simultaneously with Home Health Aide Services, or Personal Assistance 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.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Respite Worker		Home Health Agency	
			Home Care Agency	

State:	
Effective Date	

Specify whether the service may be provided by *(check each that applies):*	X	Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.	Certification as required by 42CFR Part 484	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Complete Department required training, including training on the participant's service plan and the

			participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); • Be supervised by a registered nurse; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State • licensure program that meets the requirements of Sec. 484.36 (b) or (e).
Home Care Agency	Licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries)		Agency: • Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State

			statute and in accordance with Department policies; • Have Commercial General Liability Insurance; • Have Professional Liability Errors and Omissions Insurance; • Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and • Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21. Individuals working for or contracted with agencies must meet the following standards: • Be 18 years of age or older; • Possess basic math, reading and writing skills; • Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under Title 28, Part IV Subpart H of the Health Care Facilities Act; • Have the required skills to perform services as specified in the participant's service plan; • Complete any necessary pre/in-service training related to the participant's service plan; • Agree to carry-out outcomes included in the participant's service plan; • Possess a valid Social Security number; • Must pass criminal records check as required in 55PA Code Chapter 52

			Section 52.19; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Individual Respite Worker			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Be 18 years of age or older; • Possess basic math, reading, and writing skills; • Possess a valid Social Security number; • Submit to a criminal record check; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); • Have the required skills to perform Respite Services as specified in the participant's service plan;

			• Complete any necessary pre/in-service training related to the participant's service plan; • Agree to carry-out outcomes included in the participant's service plan; and • 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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	OLTL/PA Department of Health	At least every two (2) years and more frequently when deemed necessary by the Department
Home Care Agency	OLTL/PA Department of Health	At least every two (2) years and more frequently when deemed necessary by the Department
Individual Respite Worker	Fiscal Employer Agent/OLTL	F/EA - At time of hire OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Therapeutic and Counseling Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Therapeutic and Counseling Services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

- Cognitive Rehabilitation Therapy services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.

- Counseling services are non-medical counseling services provided to participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor. If there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan, through the Office of Mental Health and Substance Abuse Services, will cover the visit outside of the home and community-based services waiver up to pre-specified limits. Counseling services are utilized only once State Plan limitations have been reached, no diagnosis is present or the service is deemed to not be medically necessary or not making meaningful progress under State Plan standards. Counseling for unpaid caregivers services must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant and be documented in

his/her service plan.

- Nutritional Consultation assists the participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant, caregiver and any providers in the implementation of the plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home Health Agencies that employ licensed and registered dieticians may provide nutritional counseling.

- Behavior Therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior Therapy services are provided by a licensed psychologist, licensed social worker, behavior specialist, or licensed professional counselor. A Masters level clinician without licensure, certification or registration, must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.

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

Participants must access State Plan services, including Outpatient Psychiatric Clinic Services, Outpatient Drug and Alcohol Services and services through the Behavioral Health Managed Care Organizations before accessing therapeutic and counseling services through the OBRA Waiver.

Therapeutic and Counseling Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or a responsible third party, such as Medicare or private insurance, unless the required expertise and experience specific to the disability is not available through the Medicaid State Plan or private insurance providers. This may be because the Medicaid State Plan, Medicare or insurance limitations have been reached, or the service is not covered under the Medicaid State Plan, Medicare or private insurance, or the provider does not have the expertise or experience specific to the disability.

The Service Coordinator is responsible for verifying and documenting in the participant's file that the Medicaid State Plan and private insurance limitations have been exhausted or that the Medicaid State Plan or private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

documented in the participant's service plan.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Registered Dietitian or Certified Nutrition Specialist		Home Health Agency	
	Licensed Psychologist			
	Licensed Social Worker			
	Licensed Professional Counselor			
	Behavior Specialist			
	Cognitive Rehabilitation Therapist			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered Dietitian or a Certified Nutrition Specialist	Licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21, subchapter G		• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA

			Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Title 49 PA Code Ch. 21 Subchapter G relates to the general provisions, licensure requirements and the responsibilities of the licensed dietician-nutritionist issued under sections 2.1(k) and 11(c) of the Professional Nursing Law (63 P. S. § 212(k) and 221(c).
Licensed Psychologist	Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41		• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker’s Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and

			• Comply with all Department standards related to provider qualifications. •
Licensed Social Worker	Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49		• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Licensed Professional Counselor	Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per		• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;

	49 PA. Code Chapter 47, 48 and 49		• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Behavior Specialist			• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; • Be a resident of Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation

			insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance in accordance with Department policies; • Be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63). • Minimum of a Master's degree in Social Work, Psychology, Education, Counseling or related human services field. Individuals without licensure or certification must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.
Cognitive Rehabilitation Therapist	Licensure specific to discipline	CBIS (Certified Brain Injury Specialist) OR Certification by Society for Cognitive Rehabilitation. Certifications or Registration specific to disciplines	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance in accordance with Department policies; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a

			component of the service; • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Individuals providing waiver services must have a Masters or Bachelor's degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degreed professional must be supervised by a licensed psychologist, a Certified Brain Injury Specialist or a professional certified by the Society for Cognitive Rehabilitation. • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and • Have a child abuse clearance (as per 23 PA C.S. Chapter 63). • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;

Home Health Agency	Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51	Certification as required by 42CFR Part 484	Agency: • Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability Insurance; • Have Professional Liability Errors and Omissions Insurance; • Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and • Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21. Individuals working for or contracted with agencies must meet the following standards: • Be 18 years of age or older; • Possess basic math, reading and writing skills; • Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under Title 28, Part IV Subpart H of the Health Care

			Facilities Act; • Have the required skills to perform services as specified in the participant's service plan; • Complete any necessary pre/in-service training related to the participant's service plan; • Agree to carry-out outcomes included in the participant's service plan; • Possess a valid Social Security number; • Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19; • Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Dietitian	OLTL/PA Department of State Board of Dietitian-Nutritionists	At least every two (2) years and more frequently when deemed necessary by the Department
Licensed Psychologist	OLTL/PA State Board of Psychology Professional Psychologists	At least every two (2) years and more frequently when deemed necessary by the Department
Licensed Social Worker	OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors	At least every two (2) years and more frequently when deemed necessary by the Department
Licensed Professional Counselor	OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors	At least every two (2) years and more frequently when deemed necessary by the Department

Behavior Specialist	OLTL	At least every two (2) years and more frequently when deemed necessary by the Department
Cognitive Rehabilitation Therapist	OLTL	At least every two (2) years and more frequently when deemed necessary by the Department
Home Health Agency	OLTL/PA Department of Health	At least every two (2) years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Adult Daily Living
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)**:**

Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

This service will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan.

Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant.

Adult Daily Living includes two components:

- Basic Adult Daily Living services
- Enhanced Adult Daily Living services.
- Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center.

Per Subchapter A, and 11.123 Core Services, the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

State:	
Effective Date	

- Nursing Requirement: The Enhanced Adult Daily Living provider shall directly provide, contract for, or otherwise arrange for nursing services. In addition to the requirements found in the Older Adult Daily Living Center (OADLC) Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the participant's service plan, with the corresponding follow-ups being made with the participant, family, or physician.
- Staff to Participant Ratio: Staffing of OADLC providing Enhanced services will be at a staff to participant ratio of 1:5.
- Operating Hours: To be eligible for the minimum rate associated with Enhanced Services, the OADLC must be open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday. (If open on a Saturday or Sunday the eleven hour requirement is not in effect for the weekend days of operation.)
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.
- Adult Daily Living providers that are certified as Enhanced receive the Enhanced full day or Enhanced half day rate for all participants attending the Enhanced center.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services.

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

Adult Daily Living services may only be funded through the waiver when the services are not covered by the State Plan, or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan, or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Adult Daily Living services with transportation cannot be provided simultaneously with Non-Medical

Transportation.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan. Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Older Adult Daily Living Center
				Adult Day Center

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Older Adult Daily Living Center	Meet licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A		• Comply with 55 PA Code 1101 and have a waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52; • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and

			• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Have a minimum of 1 year of experience providing care to an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience; • Have a high school diploma or GED; • Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code, Chapter 52; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Have disability-specific training as required by the Department.
Adult Day Center	Meet licensing regulations under Title 55 PA Code,		• Comply with 55 PA Code 1101 and have a waiver provider agreement; • Comply with Department standards,

	Chapter 2380, Subchapter A		regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52; • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania; • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age; • Have a minimum of 1 year of experience providing care to an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience; • Have a high school diploma or GED; • Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code,

			Chapter 52; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Have disability-specific training as required by the Department.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Older Adult Daily Living Center	Department of Aging/OLTL	Aging – Annually OLTL - At least every 2 years and more frequently when deemed necessary by the Department
Adult Day Center	DPW/OLTL	DPW – Annually OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Community Integration
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)**:**	
Community Integration is a short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the participant in developing maximum independent functioning in community living activities. Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a nursing facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participant's service plan. Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the participant to assure that expected outcomes are met and the service plan is modified accordingly. Services must be provided at a 1:1 ratio.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services Community Integration is reviewed quarterly to determine the progress of how the strategies utilized are affecting the participant's ability to independently complete tasks identified in the ISP. If the individual can complete the task independently, then the goal and CI service should be removed from the ISP. The length of service should not exceed thirteen (13) weeks on new plans. If the participant has not reached the goal at the end of 13 weeks, then documentation of the	

justification for continued training on the desired outcome must be incorporated into the ISP at the time of the quarterly review.

If the participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the SC must assess for a more appropriate service to meet the individual's need.

Each distinct goal may not remain on the ISP for more than twenty-six (26) weeks.

No more than 32 units per week for one CI goal will be approved in the ISP. If the participant has multiple CI goals, no more than 48 units per week will be approved in the ISP.

OLTL retains the discretion to 1) authorize CI for individuals who have not experienced a "life-changing event"; and 2) authorize more than 48 units (12 hours) of CI in one week for up to 21 hours per week and for periods longer than 26 weeks.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Community Integration Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Integration Agency			• Comply with 55 PA Code 1101 and have a waiver provider agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;

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			• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies; • Have Commercial General Liability insurance; • Professional Liability Errors and Omissions Insurance, and • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs. • Individuals working for or contracted with agencies must meet the following standards: Be 18 years of age or older; • Have a high school diploma or GED • Have a minimum of six months of paid or volunteer experience in working with people with physical disabilities and/or older adults • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Have the required skills to perform the Community Integration services specified in the participant's service plan; • Possess a valid Social Security

			number; and • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have child abuse clearance as per 23 Pa. C.S. Chapter 63. •

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Integration Agency	OLTL	At least every 2 years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Non-Medical Transportation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Non-Medical Transportation services are offered in order to enable participants to gain access to waiver services as specified in the individualized service plan. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant. Transportation services must be tied to a specific objective identified on the participant's service plan. The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Medical Assistance Transportation Program (MATP) services will be used for obtaining State Plan services. The participant's service plan must document the need for those Non-medical Transportation services that are not covered under the Medical Assistance Transportation Program. Monthly transportation costs are capped at $215 per person. Non-medical Transportation services may only be authorized on the service plan after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the participant, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs. Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. Non-Medical Transportation cannot be provided simultaneously with Personal Assistance Services.	

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The Service Coordinator will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of Transportation.

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Driver		Licensed Transportation Agency, Public Transit Authority	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Driver	Valid Pennsylvania driver's license appropriate to the vehicle	Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used to provide the Transportation service.	Drivers must meet the following: • 18 years of age; • Must have appropriate insurance coverage ($100,000/$300,000 bodily injury); • Have automobile insurance for all automobiles used to provide the Transportation service; • Vehicles must be registered with the PA Department of Transportation; • Receive a physical examination (including a vision test) at the time of hire and at least every 2 years; and • Be willing to provide door-to-door services.
Licensed Transportation Agency, Public Transit Authority	Licensed by the P.U.C and/or be a Public Transit Authority, a		Agencies must: • Meet PA Vehicle Code (Title 75); • Have Commercial General Liability insurance;

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	Community Transportation Provider or Community Transportation Subcontractor		• Have automobile insurance for all automobiles owned, leased and/or hired and used to provide the Transportation service; • Have Workers' Compensation insurance in accordance with State statute; • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, which includes, but is not limited to, communication, mobility and behavioral needs; and • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52. Drivers employed by licensed transportation agencies and public transit authorities must meet the following: • be at least 18 years of age; • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15; • Have child abuse clearance (as per 23 Pa. C.S. Chapter 63); • Agree to carry out the Transportation outcomes included in the participant's service plan; and • Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Driver	OHCDS OLTL	OHCDS verifies provider qualifications prior to service approval; annually thereafter OLTL monitors the OHCDS

		every two years
Licensed Transportation Agency, Public Transit Authority	OLTL OHCDS	OHCDS verifies provider qualifications prior to service approval; annually thereafter OLTL monitors OHCDS every two years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Residential Habilitation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 PA Code Chapter 2600). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents.

Residential Habilitation services are provided for up to 24 hours a day. This service is authorized as a day unit. A day is defined as a period of a minimum of 12 hours of service rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 am and ending at 11:59 pm. Residential Habilitation services are designed to assist an individual in acquiring the basic skills necessary to maximize their independence in activities of daily living and to fully participate in community life. Residential Habilitation services are individually tailored to meet the needs of the individual as outlined in the individual's service plan.

Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service, and is therefore

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

Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By the nature of their behaviors, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced Staffing is treated as an add-on to the Residential Habilitation service and is only available when participants require additional behavioral supports.

Residential Enhanced Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

Effective July 1, 2014 licensed settings serving individuals enrolled in the OBRA Waiver may not exceed a licensed capacity of more than 8 unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by OLTL's Office of Quality Management, Metrics and Analytics through ongoing monitoring. Additionally, Service Coordinators will monitor the community character of the residence during regularly scheduled contact with residents. Results of this monitoring will be reported to OLTL. Service Coordinators assist participants in transitioning to homes of their own.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF) or Hospital. Instead they must be located in residential neighborhoods in the community.

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

Payment is not made for room and board.

Residential Habilitation services do not include the provision of a structured day habilitation, adult daily living, supported employment, prevocational services, and therapies provided on a one to one basis.

Community Integration, Home Health Care Aide services, Non-Medical Transportation, Personal

Assistance Services, and Respite cannot be provided at the same time as Residential Habilitation.

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Licensed Residential Habilitation Provider
				Unlicensed Residential Habilitation Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Residential Habilitation Provider	Licensed by the PA Department of Public Welfare, per 55 PA Code 2600, Personal Care Homes	By July 1, 2014 those providing residential habilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider Agreement; • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52; • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania; • Have Commercial General Liability Insurance • Have Professional Liability Errors and Omissions Insurance • Have Workers Compensation Insurance in accordance with state

			statute and in accordance with Departmental policies • Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs. Individuals employed to provide Residential Habilitation services must: Be at least 18 years of age; • Have a high school diploma or GED; • Have a minimum of six months of paid or volunteer experience working with people with disabilities. • Comply with Department standards including regulations, policies and procedures related to provider qualifications; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • Complete Initial Residential Habilitation Service Training within 6 months of being hired, which consists of a minimum of 12 hours of brain injury specific training. • Complete a minimum of 12 hours of Ongoing Residential Habilitation Training annually which directly relates to job responsibilities. • Staff who are employed to provide Enhanced Residential Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be

			renewed annually. • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15; • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Agree to carry out the Residential Habilitation outcomes included in the participant's service plan.
Unlicensed Residential Habilitation Provider		By July 1, 2014 those providing residential habilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement; • Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52; • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service; • Have a waiver service location in Pennsylvania; • Have Commercial General Liability Insurance • Have Professional Liability Errors and Omissions Insurance • Have Workers Compensation Insurance in accordance with State statute and in accordance with Department policies; • Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and

			behavioral needs. Individuals employed to provide Residential Habilitation services must: • Be at least 18 years of age • Have a high school diploma or GED • Have a minimum of six months of paid or volunteer experience working with people with disabilities. • Comply with Department standards including regulations, policies and procedures related to provider qualifications; • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs; • One (1) staff must be awake and available on call at all times. • Complete Initial Residential Habilitation Service Training within 6 months of being hired, which consists of a minimum of 12 hours of brain injury specific training. • Complete a minimum of 12 hours of Ongoing Residential Habilitation Training annually which directly relates to job responsibilities. • Staff who are employed to provide Enhanced Residential Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually. • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;

			• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and • Agree to carry out the Residential Habilitation outcomes included in the participant's service plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Residential Habilitation Provider	DPW/OLTL	DPW – Annually OLTL – At least every 2 years and more frequently when deemed necessary by the Department
Unlicensed Residential Habilitation Provider	OLTL	OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Structured Day Habilitation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Structured Day Habilitation Services include supervision, training, and support to allow the participant to attain his or her maximum potential. Services include social skills training, sensory/motor development, and reduction/elimination of maladaptive behavior. Services are directed at preparing the participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Structured Day Habilitation Services take place in small group settings. Effective July 1, 2014, services must be separate from the participant's private residence or other residential living arrangement. Providers may, however, provide Structured Day Habilitation Services in the community, a participant's private residence or other residential living arrangement if the room used is used for the sole purpose of these services. The provider must operate Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of participants is not Medicaid reimbursable.

Staff to Client Ratios

- One direct care staff to 8 clients during activities
- One other individual must always be present

Structured Day Habilitation Providers that also provide Residential Habilitation are required to provide transportation to Structured Day Habilitation Services as part of Residential Habilitation Services. Structured Day Habilitation Providers are required to provide transportation to community-based activities that are provided as part of the Structured Day Habilitation service.

OLTL will consider enhanced staffing levels for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. These individuals, by the nature of their behaviors, are not able to participate in activities or are unable to access the community without direct staff support. Enhanced Structured Day Habilitation Services is an add-on to the Structured Day Habilitation Services and is only available when participants require additional behavioral supports.

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services.

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

Billing for Structured Day Habilitation:

Structured Day Habilitation Services do not include: 1:1 therapies (OT, PT, ST, Cognitive Rehabilitation Therapy, and Behavior Therapy), adult daily living, prevocational services, supported employment, personal assistance services or community integration. These services are available to participants receiving Structured Day Habilitation Services as indicated in the needs assessment and documented on the Individual Service Plan, but may not be provided simultaneously. Structured Day Habilitation Services also do not include competitive employment or higher education courses.

Transportation can be included as a separate service as indicated on the needs assessment and documented on the ISP for participants that are not also receiving Residential Habilitation Services.

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Structured Day Habilitation Agency

Specify whether the service may	☐	Legally Responsible	☐	Relative/Legal Guardian

be provided by *(check each that applies):*		Person		
Provider Qualifications (*provide the following information for each type of provider)*:				
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*	
Structured Day Habilitation Agency		By July 1, 2014 those providing structured day services must achieve CARF Community Integration accreditation, or CARF Brain Injury Home and Community Services (Adult) accreditation, or be licensed under 55 Pa Code, Chapter 2380 as an Adult Training Facility.	• Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services; • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Commercial General Liability Insurance • Have Professional Liability Errors and Omissions Insurance • Have Worker's Compensation Insurance in accordance with State statute and in accordance with Department policies. • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavior needs. • Necessary staff, to include independent education instructors, speech therapists, physical therapists, occupational therapists, behavior therapists or cognitive rehabilitation	

			therapists or other staff, to meet participant needs as outlined in the participant's service plan. All individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs • Complete initial Structured Day Habilitation Service Training within 6 months of being hired, which consists of a minimum of 20 hours of brain injury specific training. • Complete a minimum of 12 hours of Ongoing Structured Day Habilitation Training annually. • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15 • Have a child abuse as per 23 Pa. C.S. Chapter 63 • Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service In addition to the general standards listed above, Individual Support Staff must: • Be at least 18 years of age • Have a high school diploma or GED and have a minimum of five (5) years' experience working with people with

			disabilities, or • Have a Bachelor's degree in a human service field. • Staff employed to provide Enhanced Structured Day Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually • Provide assistance in therapeutic and structured group and individual activities, and assistance as required with ADLs. • Implement treatment plans, monitor individual and group progress, and document and records progress of participants served. In addition to the general standards listed above, Independent Education Instructors must: • Hold a Bachelor's degree with a current teaching certificate • Have two years of experience teaching basic adult education • Be certified under the Department of Education Develop and implement goals for the day treatment program plan, and document and record progress of individuals served. In addition to the general standards listed above, Cognitive Rehabilitation Therapists must: • Have a Masters or Bachelor's degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a bachelors or masters degreed professional must be supervised by licensed clinical psychologist, a Certified Brain Injury

			Specialist or a professional certified by the Society for Cognitive Rehabilitation. • Have Certified Brain Injury Specialist (CBIS) Certification by the Society for Cognitive Rehabilitation Certification or Registration specific to disciplines. Develop and implement goals for the day treatment program plan, and document and record progress of individuals served. In addition to the general standards listed above, Speech Therapists must: • Be licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board) • Have certification as required by 42CFR Part 484 • Develop and implement goals for the day treatment program plan, and document and record progress of individuals served. In addition to the general standards listed above, Occupational Therapists or Occupational Therapy Assistants must: • Be licensed under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board) • Have certification as required by 42 CFR Part 484 • Develop and implement goals for the day treatment program plan, and document and record progress of individuals served. In addition to the general standards listed above, Physical Therapists or Physical Therapy Assistants must:

			• Be licensed under PA Department of State, per 49 PA Code Chapter 40 (Physical Therapy Licensing Board) • Have certification as required by 42CFR Part 484 • Develop and implement goals for the day treatment program plan, and document and record progress of individuals served. In addition to the general standards listed above, professionals providing Behavior Therapy must meet the following qualifications: • Psychologist - Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41 • Social Worker - Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49 • Behavior Analyst – Licensed psychologist or Master's level clinician with Certified Applied Behavior Analysis credentials • Licensed Professional Counselor - licensed by the state of Pennsylvania as a Professional Counselor with a Master's degree or a doctorate from a CACREP-approved academic program, passed the National Counselor Examination (NCE), and completed at least 3 years or 3,600 hours of supervised clinical experience

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Structured Day Habilitation Agency	OLTL	OLTL – At least every 2 years and more frequently when

			deemed necessary by the Department	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Appendix D: Participant-Centered Planning And Service Delivery

Appendix D-1: Service Plan Development

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 *(check 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-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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*:
	Service Coordination entities are required to be conflict free as defined in 55 PA Code, Chapter 52.28. A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services except as noted below in the performance of activities as an OHCDS.

Service Coordination agencies may provide only the following services by serving as an Organized Health Care Delivery System (OHCDS).

- Community Transition Services;
- Personal Emergency Response System (PERS;
- Home Adaptations; and/or
- Non-medical Transportation

Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to select any qualified provider that has either contracted with the OHCDS or select any other qualified provider. The Service Coordination provider, who also serves as an OHCDS, cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency.

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver and their right to choose from and among all willing and qualified providers. Service Coordinators are also responsible for providing participants with information about the Services and Supports Directory - a web-based listing of all qualified and enrolled waiver providers – during the ISP development process. The information contained in the Services and Supports Directory will also be made available in a non-web-based format, as necessary or when requested. The Services and Supports Directory allows individuals receiving OLTL services, family members, service coordinators and the general public to access timely and up to date information on providers and services being offered in their area. In addition, Service Coordinators are responsible for obtaining the participant's signature on the Service Provider Choice form indicating they were fully informed of all available qualified providers and documenting receipt of the Service Provider Choice form in the participant's record. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H.

Service Coordinators provide participants with a standard packet of information developed by OLTL. The packet contains information on participant rights and responsibilities, participant choice, applying for home and community-based services programs, the role of the Service Coordinator, participant complaints, appeals and fair hearings, how to connect to other community resources, and fraud and abuse. The packet provides participants with a basis for self- advocacy safeguards.

OLTL also provides a toll-free HelpLine for participants to report concerns about their provider. This toll-free HelpLine information is incorporated into the above-referenced participant information materials, the OLTL Service Provider Choice Form and the OLTL Participant Satisfaction Surveys.

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 Service Coordinator that includes people chosen by the participant, provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions, is timely and occurs at times and locations of convenience to the individual, and reflect cultural considerations and communication needs of the individual. The Service Coordinator provides information to the individual in advance of the planning meeting so that he/she can make informed choices about their services and service delivery.

A key step in developing the ISP is to complete OLTL's standardized needs assessment, which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator reviews the information gathered with the participant, family, friends, advocates or others that are identified and chosen by the participant to be part of the service plan development process. If the participant uses an alternative means of communication or if their primary language is not English, the process utilizes the participant's primary means of communication, an interpreter, or someone identified by the participant that has a close enough relationship with the participant to accurately speak on his/her behalf.

When identifying services and supports, the participant and family, friends, advocates or others consider all available resources. The ISP includes informal supports in the participant's community, such as friends, family, neighbors, local businesses, schools, civic organizations, and employers.

Prior to the ISP meeting(s), the Service Coordinator works with the participant to coordinate invitations and ISP/Annual Review meetings, dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant.

The Service Coordinator assists the participant in the development of the ISP based on assessed needs.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect

the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The individual service plan (ISP), contains essential information about the individual, which is used for planning, and implementing supports necessary for the participant to successfully live the life that they choose. ISP's are based on written assessments and other supplemental documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs. All service plans must be developed in accordance with 55 PA Code, Chapter 52. The Commonwealth also expects that the person-centered service plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment, as well as what is important to the person with regard to preferences for the delivery of such supports. In order to make fully informed decisions, the Service Coordinator provides and reviews with the participant a standard packet of information developed by OLTL in advance of the ISP meeting. The packet contains information on participant rights and responsibilities, participant choice, applying for home and community-based services programs, the role of the Service Coordinator, participant complaints, appeals and fair hearings, how to connect to other community resources, and fraud and abuse.

Who develops plan and participates in the process:
The participant and the participant's Service Coordinator develop the service plan utilizing a participant-centered approach. This process includes the participant, people chosen by the participant, and the Service Coordinator, The Service Coordinator reviews with the participant the services available through the waiver that would benefit or assist the participant to meet the participant's identified needs. The Service Coordinator must discuss the participant's preferences and strengths including existing support systems and available community resources and incorporate those items into the ISP.

The timing of the plan and how and when it is updated:
The Service Coordinator ensures that the ISP is updated, approved, and authorized as changes occur. The Service Coordinator ensures that the ISP is reviewed and updated at least once every 365 days with the reevaluation of the participant's needs or more frequently if there is a change in the participant's needs. The Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant.

The Service Coordinator gathers information on an ongoing basis to assure the ISP reflects the participant's current needs. The Service Coordinator discusses potential revisions to the ISP with the participant and individuals important to the participant. When there is a potential change in the ISP, the Service Coordinator submits that change to OLTL through the Home and Community Based Information System (HCSIS). All changes to existing ISPs must be entered into HCSIS by Service Coordinators within three business days of identifying that the participant's needs have changed.

OLTL is responsible for the review and approval of plan changes. OLTL staff receives all ISP review alerts in HCSIS. OLTL staff reviews these alerts each work day and may request additional details or ask for clarification regarding the information that the Service Coordinator has included in the HCSIS ISP and comments. Once the ISP is authorized by

OLTL, the Service Coordinator ensures that the service plan change or changes are communicated to the participant and shared with the participant's appropriate service provider or providers to ensure that service delivery matches the approved ISP. Changes to the ISP must be approved by OLTL prior to initiating changes in the service plan.

The types of assessments that are conducted:
Part of the enrollment process involves the local Area Agency on Aging (AAA) assessor's completion of a level of care assessment tool to determine whether the participant meets the Nursing Facility level of care. In addition a physician completes a physician certification form which indicates the physician's level of care recommendation.

At the time of enrollment, the independent enrollment broker completes the OLTL's standardized needs assessment, which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator uses the information gathered from the level of care assessment and the standardized needs assessment to develop the participant's Individual Service Plan.

The Service Coordinator also reviews and updates the needs assessment at least once every 365 days or on an as needed basis to determine if the ISP requires any changes. If there are changes in the participant's needs, the Service Coordinator must revise the ISP and have the participant sign the signature page of the ISP.

How the participant is informed of the services available under the waiver:
The Service Coordinator is responsible to ensure all waiver participants are informed of home and community-based services funded through the OBRA Waiver. The Service Coordinator describes and explains the concept of participant-centered service planning, as well as the types of services available through the CommCare Waiver, to the participant at home visits and through ongoing discussions with the participant. In addition to describing the services available through the waiver, the SC also provides detailed information (described further in Appendix E) regarding opportunities and responsibilities of participant direction. These discussions are documented in the HCSIS service notes for each participant.

How the process ensures that the service plan addresses participant's desired goals, outcomes, needs and preferences:
The Service Coordinator reviews the participant's assessed needs with the participant to identify waiver and non-waiver services that will best meet the individual's goals, needs, and preferences. If non-waiver services are not utilized, justification must be provided in the service notes for the use of waiver services. In addition, Service Coordinators review with the participant their identified unmet needs and ensures that the service plan includes sufficient and appropriate services to maintain health, safety and welfare, and provides the support that an individual needs or is likely to need in the community and to avoid institutionalization.

The Service Coordinator utilizes the assessments and discussions with the participant to secure information about the participant's needs, including health care needs, preferences,

goals, and health status to develop the ISP. This information is captured by the Service Coordinator onto a standard service plan form and then documented in the Home and Community Services Information System (HCSIS). OLTL reviews the participant's record in HCSIS against the requirements. The QMET review a sample of claims to ensure they meet the type, scope, amount, duration and frequency of services listed in the ISP. Furthermore, QMET reviews to ensure services are delivered in the type, scope, amount, duration and frequency as indicated in the approved ISP.

To ensure health care needs are addressed, a registered nurse is either on staff with the Service Coordination Entity or is available under contract as a nursing consultant to the Service Coordination Entity. The RN is required to review and sign the standardized needs assessment for individuals who are ventilator dependent, technology dependent, require wound care, are non-compliant with medications, non-compliant with self-care or if the participant requests to have an RN involved with the assessment of needs. The Service Coordinator is responsible for notifying waiver participants that an RN is available should the participant wish to have a nurse included in the assessment process. This option is also incorporated into the standardized information packets that are distributed to all waiver participants.

The Service Coordinator, in conjunction with the participant, gathers information on an ongoing basis to assure the ISP reflects the participants' needs. Revisions are discussed with the participant and entered into the ISP in HCSIS for OLTL review and if approved by OLTL, the updated service information is shared with the participant and service providers.

All service plan meetings and discussions with the participant are documented in the service notes.

How responsibilities are assigned for implementing the plan:
SCs are responsible for addressing and documenting the following information in the ISP to meet the requirements of OLTL for approval and implementation:
OLTL services reflect identified unmet needs
Participant's goals, strengths, and capabilities
Coordination of waiver/program and non-waiver/program services
Justification of services
Preferences addressed
Third Party Liability
Informal Supports
Community resources
Any barriers/risks
Assignment of responsibilities to implement and monitor the plan
Individual back-up plan
Emergency back-up plan
Freedom of choice of service alternatives
Choice of providers is offered
Chosen service model
Chosen providers
Review of rights and responsibilities

Contact with the participant, families and providers in service/journal notes
Individuals who participated in the development of the ISP
The frequency and duration of all services

The SC must obtain the signatures of the participant, participant's representative and any others involved in the planning process, indicating they participated in, approve and understand the services outlined in the ISP and that services are adequate and appropriate to the participant's needs. Every participant must receive a copy of his/her ISP. A copy of the signed ISP is given to the participant and a copy of the signed ISP must be kept in the participant's file at the SC Entity.

The Service Coordinator, in conjunction with the participant, is responsible for developing ISPs and updating annually by performing the following roles in accordance with specific requirements and timeframes, as established by OLTL:

- Developing the initial ISP, and subsequent revisions as required
- Entering ISP's into HCSIS

Conducting the annual reevaluation at least once every 365 days and whenever needs change

- Documenting contacts with individuals, families and providers
- Recordkeeping
- Locating services
- Coordinating service coverage through internal or external sources
- Monitoring services
- Ensuring health and welfare of waiver participants
- Follow-up and tracking of remediation activities
- Sharing information
- Assuring information is in completed ISP
- Participating in ISP reviews
- Coordinating recommended services

Assuring participants are given choice of providers at least annually at the reassessment visit

- Reviewing plan implementation

The direct service provider is responsible for providing the services in the amount, type, frequency, and duration that is authorized in the ISP. The provider is responsible to notify the participant's SC when the participant refuses services or is not home to receive the services as indicated in the authorized ISP.

The participant is responsible to notify their service provider when they are unable to keep scheduled appointments, or when they will be hospitalized or away from home for a significant period of time. The participant is responsible for notifying their SC when a provider does not show up to provide the authorized services and is responsible to initiate their individual back-up plan in such instances.

How waiver and other services are coordinated:
A team consisting of the participant, Service Coordinator, and others of the participant's choosing consider all other potential sources of coverage as part of the service plan development process. The team reviews for any service coverage that may be available

under the State Plan or other possible Federal programs or non-governmental programs before utilizing waiver services. The team also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the person's health, safety and welfare in the most cost effective manner. All identified services, whether available through the waiver or other funding sources, are outlined in the participant's ISP, which is distributed by the Service Coordinator to the participant and providers of service. The Service Coordinator is responsible for ensuring that there is coordination between services in the ISP, including facilitating access to needed State Plan benefits, maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers. Justification for limitations and/or not utilizing non-waiver services must be documented in service notes. OLTL reviews service plans to ensure that non-waiver resources, including MA covered services including State Plan Covered Services, are documented on the participant's ISP.

The assignment of responsibility to monitor and oversee the implementation of the service plan:
Upon authorization of the ISP, the Service Coordination Entity forwards a copy of the OLTL Service Authorization Form to identified service providers. The Service Authorization Form provides detailed information regarding the type, scope, amount, duration, and frequency of the service authorized. Also included on the form are 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 rendered by the provider. The Service Coordinator must communicate service plan approval and changes to the participant and the appropriate service provider to ensure that service delivery is consistent with the approved ISP. The Quality Management Efficiency Teams (QMET) review the service plan against participant records and claims at a minimum biennially to ensure that the type, scope, amount, duration and frequency of services is actually provided by the direct service provider. The QMET also review the service coordination notes to ensure that the Service Coordination Entity is monitoring that services are appropriately delivered. The appropriate delivery of services is a regulatory requirement of all service providers, and failure to deliver services as identified in the ISP result in a Statement of Findings and potential penalties against the provider including and up to disenrollment.

Service Coordinators are responsible for monitoring the full implementation of the service plan, including the health, safety and welfare of the participant and the quality of the participant's service plan through personal visits at a minimum of twice per year and telephone calls at least quarterly. Service Coordinator monitoring ensures that reasonable safeguards exist for the person's health and well-being in the home and community. Personal visits and telephone contacts can be done more frequently to assure provision of services and health and welfare of the participant.

Service Coordinators are responsible for documenting and monitoring the following:
- The participant is receiving the amount (units) of services that are in the ISP
- The participant is receiving the frequency of services that are in ISP.
- The participant receives the authorized services that are in the ISP.

- The participant is receiving the duration of services that are in the ISP.

OLTL monitors ISPs as part of the biennial monitoring for compliance with waiver requirements and ISP policies. OLTL also provides a toll-free HelpLine for participants to report concerns about their provider or the delivery of services. The toll-free HelpLine information is provided at enrollment, at annual reevaluations, and during the Service Coordinator's participant service monitoring visits.

During the course of performing Retrospective Review of service plans, BQPM staff may notice issues regarding the implementation of the plan or regarding health and safety. BQPM staff notifies BPO staff for further investigation and resolution of such issues. While reviewing service plans, BQPM staff also looks at the participant's history of incidents and complaints, and provide these details to BPO in addition to issues from the plan. Additional information regarding Retrospective Reviews of service plans is available in the Quality Improvement Section of this Appendix.

The individual service plan (ISP), contains essential information about the individual, which is used for planning, and implementing supports necessary for the participant to successfully live the life that they choose. ISP's are based on written assessments or other documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs

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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 assessment process includes the identification of potential risks to the participant.

Risks are initially assessed through the level of care assessment process and the standardized needs assessment that is completed during a face-to-face interview with the individual at the time of enrollment. Through the level of care assessment and the needs assessment, risks will be identified and summarized into categories according to health/medical, community, and behavioral risks. The Service Coordinator will discuss these potential risks with the participant and whomever the participant chooses to have present such as the participant's family and friends during the development of the ISP. The Service Coordinator, participant and any other participant chosen individuals will identify strategies to mitigate such risks that will allow participants to live in the community while assuring their health and welfare. These strategies to prepare for risk are as individualized as the potential risks themselves, and will be incorporated into the ISP. The participant signs a statement as part of the ISP signature page agreement that indicates the Service Coordinator reviewed the risks associated with the participant's goals. This process will verify that the participant has participated in the discussion and has been fully informed of the risks associated with his/her goals, and any identified

strategies included in the plan to mitigate risk, while respecting the individual's choice and preferences in the service planning process.

The Service Coordinator will also describe any unique circumstances on the service plan. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant 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.

Emergency back up plans and priority arrangements to ensure the health, safety and welfare of the participant are developed and documented during the ISP development process. Emergency back up plans are also part of the ongoing service plan monitoring process at the Service Coordinator level. All participants are required to have individualized backup plans and arrangements to cover services they need when the regularly scheduled service worker is not available. Strategies for back up plans may include the use of family and friends of the participants' choice and/or agency staff, based on the needs and preferences of the participant. If the backup plan fails, participants may utilize the agency model to provide emergency backup coverage to meet their immediate needs. The Service Coordinator may reach out to and utilize other home health or home care agencies for backup if necessary and document the details in the ISP. The Service Coordinator is responsible during regular monitoring to validate that the strategies and backup plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Service Coordinators to report disruptions of backup plans and strategies. The service plan assessment process includes the identification of potential risks to the participant. The Service Coordinator will discuss these potential risks with the participant and whomever the participant chooses to have present such as providers, the participant's family and friends during the development of the ISP. The Service Coordinator, participant and any other participant chosen individuals will identify strategies to mitigate such risks that will allow participants to live as they choose in the community while assuring their health and welfare. These strategies will be incorporated into the ISP. The Service Coordinator will also describe any unique circumstances on the service plan. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant 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.

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.

At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services. Participants are free to change providers at any time by informing their Service

Coordinator of the desire to make a change.

Participants may also identify other non-waiver providers from whom they would like to receive services. This information will be given to the OLTL or designee who will make every attempt to recruit and enroll the provider in the waiver program.

A current listing of enrolled providers is maintained by OLTL in the Services and Supports Directory. This listing is maintained in HCSIS and automatically updated as new providers are enrolled. The Services and Supports Directory is shared with participants by both the enrollment agency as well as service coordination providers.

Participants are also given the toll free 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 (including Service Coordination agencies) that provide the services in their service plan. The toll-free HelpLine information is provided to participants at time of enrollment, at annual reevaluations, and during Service Coordinator's participant service monitoring visits.

The enrolling agency is responsible for ensuring all individuals who are determined eligible for waiver services are given a list of all enrolled service coordination providers, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form.

The Service Coordinator is responsible for ensuring participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination Entity is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form

The OLTL Service Provider Choice Form emphasizes to participants that they have the right to choose any qualified provider, and that they cannot receive service coordination and service plan services from the same provider. The OLTL Service Provider Choice Form serves to document each individual's choice.

OLTL staff reviews service plan information in the Home and Community Services Information System (HCSIS). Service Coordination providers are required to confirm in HCSIS that the standard OLTL Service Provider Form has been completed whenever the Service Coordination provider submits a plan creation or plan revision to OLTL.

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):

OLTL reviews and approves all service plans. The Service Coordinator, in conjunction with the participant, is responsible to modify the ISP if the participant's needs change.

When there is a change in the ISP, the Service Coordinator submits that potential change to OLTL through HCSIS. OLTL is responsible for the review and approval of ISP changes in HCSIS. OLTL reviews a representative sample of ISPs as described in the Quality Improvement

section of this Appendix. In addition, OLTL ensures that participant's ISPs are developed according to OLTL requirements and in a fashion that supports participant's health and welfare through the Service Coordination oversight process.

Service Coordinators are required to review and update the participants ISP at least once every 365 days and submit the annual review in HCSIS. OLTL reviews a representative sample of service plans as described in the Quality Improvement section of this Appendix. As stated above, OLTL ensures that participant's service plans are updated according to OLTL requirements and in a fashion that supports participant's health and welfare through the Service Coordination oversight process.

The process of developing and revising service plans is monitored by OLTL as listed in the Quality Improvement section of this Appendix.

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*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies)*:

☑	Medicaid agency
☐	Operating agency
☑	Case manager
☐	Other (*specify):*

Appendix D-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 Service Coordinator plays a key role in ensuring the implementation and monitoring of the ISP as follows:

- Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may

be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. During monitoring contacts the SC is responsible for discussing the following information with the participant and documenting the information in HCSIS service notes for review by OLTL:

- The participant is receiving the amount, frequency, and duration of services that are in the approved ISP.
- The participant is receiving the authorized services that are in the ISP.
- The participant is receiving the amount of support necessary to ensure health and safety.
- If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes
- There is no duplication of services including waiver and non-waiver services.
- Contacts with individuals, families and providers.
- Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP.
- That the recommended and chosen services are being implemented.
- That the back-up plan is effective and how often it has been used.

- Initiates and oversees the process of reevaluation of the participant's level of care and review of ISP

- Addresses problems and concerns of participants on an as needed basis and report to OLTL with unresolved concerns

OLTL reviews and approves the ISP through HCSIS. The Service Coordinator receives an alert of approval or disapproval from OLTL in HCSIS once the ISP is reviewed by OLTL staff. The Service Coordinator implements services once the ISP is approved by OLTL.

Additionally, the Quality Management Efficiency Teams monitor the following activities as being provided by the Service Coordination activity. These activities are listed requirements in 55 Pa. Code § 52.26 (service coordination services).

- Services furnished in accordance with the service plan;
- Participant access to waiver services identified in service plan;
- Participants exercise free choice of provider;
- Services meet participants' needs;
- Effectiveness of back-up plans;
- Participant health and welfare; and
- Participant access to non-waiver services in service plan, including health services.

If a provider fails to meet a regulation or waiver requirement, a Corrective Action Plan is issued. For more information on the Corrective Action Plan process, please refer to Appendix C. Furthermore, OLTL has the option to enact sanctions against the provider for failure to meet a regulation, up to and including disenrollment.

Any deficiencies or issues identified through the review of the ISP will be presented to the Service Coordination Entity for remediation. The Service Coordinator will be notified through communication from the Bureau of Participant Operations (BPO) in the comments section of HCSIS. The BPO will expect the Service Coordination Entity to outline a plan to correct the issue(s) and submit to BPO for approval and follow up with notification of remediation. The plan should include communication strategies for notifying the participant of any service that may be affected due to the discrepancy or inappropriateness of the service they have coordinated.

During the course of performing Retrospective Review of service plans, BQPM staff may notice issues regarding the implementation of the plan or regarding health and safety. BQPM staff notifies BPO staff for further investigation and resolution of such issues. While reviewing service plans, BQPM staff also looks at the participant's history of incidents and complaints, and provide these details to BPO in addition to issues from the plan. Additional information regarding Retrospective Reviews of service plans is available in the Quality Improvement Section of this Appendix.

In addition, the F/EA assists both OLTL and the Service Coordinator in monitoring service utilization for participants who are self-directing their services. The F/EA is required to provide monthly reports to common law employers, service coordinators, and OLTL which display individual service utilization (both over and underutilization) and spending patterns. The F/EA is also responsible for providing written notification to the Service Coordinator of any common law employer who does not submit timesheets for two or more consecutive payroll periods.

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*:
	Service Coordination entities are required to be conflict free as defined in 55 PA Code, Chapter 52.28. A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services. Service Coordination entities may provide the following services under an Organized Health Care Delivery System (OHCDS): • Community Transition Services; • Personal Emergency Response System (PERS; • Home Adaptations; and/or • Non-medical Transportation Participants are not required to receive vendor services subcontracted through an

	OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS, or select any other enrolled qualified provider. The Service Coordination provider cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency. Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all wiling and qualified providers. Service Coordinators are responsible for providing participants with a list of approved qualified providers from the Services and Supports Directory – a web-based listing of all qualified and enrolled waiver providers – to the participant during the ISP development process, and obtain the participant's signature on the Service Provider Choice form, indicating they were fully informed of all available qualified providers. The Services and Supports Directory allows individuals receiving OLTL services, family members, service coordinators and the general public to access timely and up to date information on providers and services being offered in their area. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H. OLTL also provides a toll-free HelpLine for participants to report concerns about their provider. This toll-free HelpLine information is incorporated into the OLTL Service Provider Choice Form.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

●	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
●	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Directed Opportunities Available within the OBRA Waiver:
All participants in the OBRA waiver have the right to make decisions about and self-direct their own waiver services and may choose to hire and manage staff using Employer Authority. Under Employer Authority, the participant serves as the common-law the employer and is responsible for hiring, firing, training, supervising, and scheduling their support workers. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

How Participants May Take Advantage of Self-Directed Opportunities:
Participants may choose to self-direct their services during the development of the initial Individual Service Plan (ISP), at reassessment, or at any time. The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of opportunities within the waiver. As described in Appendix E-1-e below, the Office of Long-Term Living has developed standardized educational materials and promotional materials with information about self-direction for all waiver participants. OLTL has also developed and provided regional on-site training for Service Coordinators on self-direction to ensure information is provided accurately and consistently statewide.

As stated previously, the participant may utilize a combination of any model(s) to personalize their service plan. The ISP is developed in conjunction with the Service Coordinator, as described in Appendix D, to ensure that the participant's service needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer all participants who have chosen to self-direct their services provider-managed services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their Service Coordinator. Service Coordinators must work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

Entities That Support Individuals:
Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing Employer Authority will receive support from a certified Fiscal/Employer Agent (F/EA) and Service Coordinators to assist them in their role as the common-law employer of their workers. The Fiscal/Employer Agent will:

- Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
- Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
- Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
- Establish and maintain a separate bank account for the purposes of managing participant directed funds and provide a full accounting of the use of these funds;
- Conduct criminal background checks and when applicable, child abuse clearances, on potential

employees;
- Assist participants in verifying support workers citizenship or alien status;
- Distribute, collect and process support worker timesheets as verified and approved by the participant;
- Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
- Broker workers' compensation for all support workers through an appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
- Assist in implementing the state's quality management strategy related to FMS;
- Establish an accessible customer service system for the participant and the Service Coordinator; and
- Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL.

In addition, individuals choosing to self-direct their services will receive assistance from their Service Coordinator to develop their Individual Service Plan (ISP). Once the ISP is developed, approved, and authorized, the participant is responsible for arranging and directing the services outlined in their plan with, as appropriate, information and support from the Service Coordinator. During the implementation and management of the ISP, the Service Coordinator will:
- Assist the participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the participant to develop an individualized back-up plan;
- Assist the participant to identify risks or potential risks and develop a plan to manage those risks;
- Monitor the provision of services to ensure the participant's health and welfare;
- Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services; and
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

●	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a

	budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☑	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
●	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of participant direction opportunities within the waiver. The Service Coordinator documents the participant's choice of service delivery model on the ISP. Participants are also advised that they have the opportunity to change their model of service at any time throughout the year. Participants receive information about participant-direction at time of enrollment, on an annual basis and upon request.

The Office of Long-Term Living has developed consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials include a comprehensive participant reference manual which contains details about participant-direction roles, responsibilities, and informed decision-making. These materials have been distributed to the Independent Enrollment Broker as well as all Service Coordination

agencies, and are available on the OLTL website. This information is widely available and shared with individuals upon entering service, at monitoring contacts and during annual ISP updates each year thereafter. This information is written at a level that is easily understood using every day common language to ensure accessibility, and is provided in advance of the ISP meeting to ensure that individuals have sufficient time to consider their options and the responsibilities.

The F/EA, a single statewide entity providing consistent functions across the Commonwealth, is responsible for providing orientation and training to the participant prior to employing their support service worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Support Service Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
-
- Effective practices for recruiting potential employees, hiring employees, training employees, supervising and managing employees and firing employees;
- The process for resolving issues and complaints; and
- Workers Compensation and the process for reviewing workplace safety issues.

In addition, the F/EA is responsible for providing ongoing skills training to participants and working with Service Coordinators to identify any participants who may need and/or desire additional employer skills training.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
●	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☑	Waiver services may be directed by a legal representative of the participant.
	☑	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		Waiver services may be directed by a non-legal representative freely chosen by an adult participant or for any individual who is unable to: • Understand his/her own personal care needs • Make decisions about his/her own care • Manage his/her lifestyle and environment by making these choices • Understand or have the ability to learn how to recruit, hire, train, and supervise providers of care; or • Understand the impact of his/her decisions and assume responsibility for the results. The individual, a Service Coordinator, the OLTL, or the F/EA may request a personal representative be appointed, if indicated. A personal representative may be a legal guardian, or other legally appointed

personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- A strong personal commitment to the participant;
- Assist the participant in identifying/ obtaining back up services when a support worker does not show;
- Demonstrate knowledge of the participant's preferences;
- Agree to predetermined frequency of contact with the participant as mutually determined by the participant, the personal representative and the Service Coordinator; and
- Be at least 18 years of age.

The Service Coordinator or F/EA may request a personal representative be appointed when circumstances indicate a change in the participant's ability to self-direct or when the participant demonstrates misuse of funds, consistent non-adherence to program policy or an ongoing health and welfare risk.

A representative may not be a paid attendant for the participant.
The F/EA must recognize the participant's personal representative as a decision-maker, and provide the personal representative with all of the information, training, and support it would typically provide to a participant who is self-directing. The F/EA must fully inform the personal representative of the rights and responsibilities of a representative. Once informed, the F/EA must have the representative review and sign the standard Common Law Employer Designation Form, which must be given to the representative and maintained in the participant's file. The agreement lists the roles and responsibilities of the representative; states that the representative accepts the roles and responsibilities of this function; and states that the representative will abide by OLTL policies and procedures.

The Service Coordinator is responsible for ensuring the personal representative functions in the best interest of the participant through, at minimum, quarterly monitoring calls, by monitoring the personal representative's adherence to the Common Law Employer Designation Form, and ensuring services are being provided as outlined in the participant's ISP. When it appears the personal representative is not acting in the best interest of the participant, and there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP, the Service Coordinator must explore other alternatives, such as appointing a new personal representative or transitioning the participant to the provider managed service delivery model as described in Appendix E-1-m below. The Service Coordinator is also required to report any incidents of suspected abuse, neglect and/or exploitation as described in Appendix G.

In addition, the F/EA is required to address and report any issues identified with the representative OLTL policy on incident reporting and report any incident of suspected fraud or abuse.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	☑	☐
Respite	☑	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

●	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	☑	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3. *Provide the following information:*
●	FMS are provided as an administrative activity. *Provide the following information:*
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	Financial Management Services are provided to participants across the Commonwealth by one qualified Fiscal Employer Agent, which was selected through a competitive procurement process (RFA). The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	•The statewide F/EA receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. The monthly administrative fee was established through the competitive procurement process. The selected vendor must apply the monthly per participant fee consistently with each participant enrolled with the vendor.

		•A one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee. The one-time start-up administrative fee is established by DPW. The one-time per participant start-up fee and the ongoing per member per month administrative fee may not be billed simultaneously. Payment for Financial Management Services is not based on a percentage of the total dollar volume of transactions that the FMS entity processes. The percentage of FMS costs relative to the participant's service costs are independent of one another, as service costs are based upon the assessed needs of the participant.
iii		**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
	☑	Assist participant in verifying support worker citizenship status
	☑	Collect and process timesheets of support workers
	☑	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☑	Other *(specify):* • Enroll participants in FMS and apply for and receive approval from the IRS to act as a an agent on behalf of the participant; • Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal, state, and local tax forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation; • Conduct criminal background checks, child abuse clearances when applicable, on potential employees; • Distribute, collect and process support worker timesheets as verified and approved by the participant; • Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan; • Compute, withhold, file, deposit and track federal, state and local income taxes in compliance with all federal, state, and local requirements; • Broker workers' compensation for all support workers through the appropriate agency; • Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws; • Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually; • Assist in implementing the state's quality management strategy related to FMS • Establish an accessible customer service system for the participant and Service Coordinator. • Assist participants in verifying support workers citizenship or alien status; and

		• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL
	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance-of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☑	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☑	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	The statewide F/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with the OLTL F/EA contract requirements. The F/EA FMS provides specific employer agent functions that support the participant with the employer-related functions. The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. If the F/EA is not in compliance with contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves	

	or disapproves the CAP within 15 days of receipt. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of monthly utilization reports, quarterly and annual status reports, as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. Service Coordinators will also be required to report any issues with the statewide FMS organization's performance to OLTL. Lastly, the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool provided by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department. Through the established claims oversight process, OLTL will monitors claim submitted by the F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
☑	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:	**Service Coordination**
☑	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*	
	The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities to provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA. The selected F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. In addition, a one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The initial start-up administrative fee will be authorized for each participant in	

the month prior to authorization of the ongoing monthly per participant administrative fee The monthly administrative fee was established as part of the competitive procurement process; the one-time start-up administrative fee is established by DPW.

Participants will obtain enrollment and informational materials from the selected F/EA organization under contract with OLTL. In addition, the F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- • Effective practices for hiring, training, and supervising employees;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues.

In addition, individuals choosing to self-direct their services will receive assistance and support from their Service Coordinator. The Service Coordinator will:

- Provide participants with information regarding self-direction on an ongoing basis, including information about responsibilities, rights and concepts of self-direction;
- Work with the F/EA and the participant as necessary to ensure all enrollment and employment paperwork is completed and sent to the F/EA;
- Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services;
- Assist the participant to develop job descriptions for support workers to be employed by the participant. Job descriptions must be consistent with the individual service plan;
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.
- Assist the participant in communicating with the F/EA as needed;
- Support the participant in problem-solving, decision-making, and recognizing and reporting critical incidents; and
- Monitor the provision and utilization of services to ensure the participant’s health and welfare.

The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected F/EA prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. OLTL will monitor the selected F/EA to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide F/EA will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. If the FMS organization is not in compliance with a contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL

	will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary.

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
●	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants have the option to transition from participant direction to the provider managed service delivery model at any point during their waiver enrollment. When a participant voluntarily chooses to terminate participant direction, they will contact their Service Coordinator who will guide them through the process of transition. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period. The change in models will be reflected on a revised ISP.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants, or personal representatives, who demonstrate the inability to self-direct their services whether due to misuse of funds, consistent non-adherence to program policy or an on-going health and welfare risk, will be required to transition to provider managed services.

Involuntary Termination from participant direction may also occur after it has been determined that there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP. Involuntary termination would only occur after a thorough review of the participant's health and welfare needs as identified in the service plan.

Termination of participant direction would occur only after a team meeting with the participant, the participant's Service Coordinator, and any family, friends and advocate if requested by the participant and a review of the recommendations by the OLTL.

The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period.

The participant has the right to an Appeal and Fair Hearing and will be given this opportunity as outlined in Appendix F-1 Right to a Fair Hearing.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect

each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	700	
Year 2	700	
Year 3	700	
Year 4 (renewal only)	700	
Year 5 (renewal only)	700	

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:*
☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☑	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☑	Hire staff (common law employer)
☑	Verify staff qualifications
☑	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	To ensure all participants make an informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services The FMS agency secures and pays for the criminal background check.
☑	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☑	Determine staff duties consistent with the service specifications in Appendix C-3.
☑	Determine staff wages and benefits subject to applicable State limits
☑	Schedule staff
☑	Orient and instruct-staff in duties
☑	Supervise staff
☑	Evaluate staff performance
☑	Verify time worked by staff and approve time sheets

☑	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the

	service plan.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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 OLTL Participant Information Packet, containing information about appeals and fair hearings, is distributed to the participant at enrollment and during the ISP annual review meeting.

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 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 on 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 IEB/Service Coordinator are required to make all such notices in writing utilizing OLTL issued documents. Should the applicant/participant 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/IEB 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 applicant or participant.
- Providing the necessary forms and explaining to the applicant or participant how to file his or her appeal and, if necessary, how to fill out the forms.
- Advising the applicant 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). AAA participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the initial level of care determination and the individual appeals that notice through the CAO. Service Coordinators are expected to participate when the CAO sends a notice confirming the level of care redetermination and the individual appeals that notice through the 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, which is sent by the Service Coordinator, 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-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*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
●	**No**. This Appendix does not apply (*do not complete Item b)*

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.

Appendix F-3: State Grievance/Complaint System

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

●	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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).

OLTL operates a Customer Service line, also known as the OLTL HelpLine. The OLTL HelpLine (1-800-757-5042) is located in the Bureau of Participant Operations and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services, provider performance, and reports of alleged abuse, neglect or exploitation.

Individuals calling the OLTL HelpLine with a complaint/grievance are logged into the Enterprise Information System (EIM), a web-based database, and the information is then referred to the appropriate Bureau for resolution. Complaints are classified as Urgent if immediate action is required to assist in safeguarding the participant's health and welfare or Non-Urgent if the participant is not at risk of immediate health and jeopardy and immediate action is not required. Any complaints determined to be an incident as described in Appendix G are entered into EIM as an incident and are treated as such for purposes of investigation and follow-through.

Investigations of Urgent complaints must be initiated with one business day, while Non-Urgent complaints have a five day timeframe for complaint initiation of the investigation. Any complaint determined to be an incident as described in Appendix G will be handled in accordance with all applicable requirements. The receiving Bureau contacts the participant, their service coordinator, and/or other necessary parties in order to determine all circumstances regarding the complaint and to make a determination about an appropriate resolution. Documentation of any actions and the resolution is entered into the database by OLTL staff and the complaint is submitted through EIM for supervisory review. The reviewing supervisor can accept the resolution allowing for closure of the complaint or send it back to staff for further action. The timeframe for additional follow-up and resolution is 45 days, but additional time can be requested through EIM in accordance with OLTL requirements. OLTL is able to generate reports from EIM about the types of participant complaints received, timeliness of resolution and examines general patterns and trends for system improvement.

In addition, EIM is designed to collect complaints received from any source, such as direct phone calls, emails, and letters or faxes in order to standardize collection and processing of all complaints in one data collection system. Participants are informed verbally and in the OLTL Participant Information Packet about the OLTL Participant HelpLine at enrollment, during their annual reevaluation, and in the cover letter that accompanies the OLTL Participant Satisfaction Surveys.

Participants are advised through OLTL's standard participant information materials that OLTL's grievance/complaint system is neither a pre-requisite, nor a substitute for a fair hearing.

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 Office of Long-Term Living has initiated a comprehensive incident reporting and management process. Critical events are referred to as critical incidents and defined as an event that jeopardizes the participant's health and welfare. Two OLTL offices are involved in the oversight of the Incident Management process – the Bureau of Quality and Provider Management (BQPM) and the Bureau of Participant Operations (BPO).

Definitions of the types of critical events or incidents that must be reported:
As defined in 55 Pa. Code, Chapter 52, the following are considered critical incidents:
1. Death (other than by natural causes);
2. Serious Injury - that results in emergency room visits, hospitalizations, and death;
3. Hospitalization - except in certain cases, for example hospital stays that were planned in advance;
4. Provider and staff misconduct – deliberate, willful, unlawful, or dishonest activities;
5. Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse are, but not necessarily limited to:
- Physical abuse – defined as a physical act by an individual that may cause physical injury to a participant;
- Psychological abuse – an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
- Sexual abuse – an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
- Verbal abuse – using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant.

6. Neglect – the failure to provide a participant the reasonable care that he, or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.

7. Exploitation – the act of depriving, defrauding, or otherwise obtaining the personal property from 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;
8. Service Interruption – Any event that results in the participant's inability to receive services that places his, or her health, and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization.
9. Medication errors that require medical intervention, for example, hospitalization, or emergency room visits.

Individuals/entities that are required to report critical events:
Per 55 PA Code Chapter 52 and OLTL's Critical Incident Management Bulletin, administrators and employees of waiver service providers, including Service Coordination Entities, and individual providers of waiver services, are responsible for reporting critical incidents through the electronic Incident Management system, an electronic data system that collects information regarding critical incidents involving waiver participants. In addition, Direct service providers are required to notify the participant's Service Coordinator when a critical incident occurs.

In addition to reporting an incident to OLTL, in the event a direct service provider/Service Coordination Entity has reasonable suspicion that a participant over age 60 is the victim of a crime, including abuse, neglect or exploitation, or that death is suspicious, the provider must also report to the local Older Protective Services Act (OAPSA) Agency and the Department of Aging of knowledge of the incident. In the event a provider has reasonable suspicion that a participant ages 18 to 59 is the victim of abandonment, abuse, exploitation, intimidation, neglect, serious injury or bodily injury or sexual abuse, the provider must immediately report to the Adult Protective Services (APS) Office of the Department of Human Services. For both OAPSA and APS, the direct service provider/Service Coordination Entity must also immediately contact the appropriate law enforcement official to file a report when incidents involve sexual abuse, serious injury, serious bodily injury or suspicious death. For both OAPSA and APS, the provider must also inform the participant's Service Coordination Entity within 24 hours of knowledge of the incident. The provider must also immediately contact the appropriate law enforcement official to file a report. These additional reporting requirements do not supplant a provider's reporting responsibilities to OLTL.

Reporting applies to:
- Critical incidents that occur during the time the provider is providing services, and
- Critical incidents that occur during the time the provider is contracted to provide services, but fails to do so, and
- Critical incidents that occur at times other than when the provider is providing, or is contracted to provide services if the administrators, or employees become aware of such incidents.

In addition to reports received from providers through the Enterprise Incident Management (EIM) system, reports are taken from participants, families or other interested parties through OLTL's toll-free Participant HelpLine. Additional information regarding the HelpLine is contained in Appendix F.

Timeframes within which critical events must be reported and the methods for reporting:
Required reporters must report critical incidents to OLTL, and Service Coordination Entities when applicable, within 24 hours of their occurrence or discovery. OLTL has initiated a mandatory electronic reporting system for reporting all critical incidents. The electronic reporting system, referred to as EIM (Enterprise Incident Management), allows Service Coordinators and Direct Service providers to submit critical incident through a

web-based application where they are accessed by OLTL staff.

Incidents reported through the OLTL Participant HelpLine are entered into EIM by OLTL staff and the incidents are handled the same way as those reported directly through the web-based application. The following information is collected for each reported incident, regardless of how it is received: reporter information, participant demographics, OLTL program information, event type/details and description of the incident.

Reporters are notified through EIM that their incident reports have been received. OLTL staff reviews the critical incidents daily to check for completeness and to ensure that what has been reported is truly a critical incident. Supervisors in BPO check the EIM dashboard daily for new incidents and refer cases to their staff for follow-up and action as appropriate.

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.

At time of enrollment, the IEB informs participants of the incident management process. This information is provided through the participant information materials developed by OLTL. These materials include how to recognize and report abuse, neglect and exploitation, as well as the prohibition on the use of restraints. In addition, the information includes OLTL's toll free number and the process for reporting these occurrences to either the participant's Service Coordinator or OLTL directly. The Service Coordinator is responsible for reviewing this information at least annually with the participant at time of reassessment or if there is suspicion of abuse, neglect, exploitation or abandonment.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entity (or entities) that receives reports of each type of critical event or incident.
BPO receives reports through EIM, the Participant Helpline and any other source and evaluates all critical incidents as defined in Appendix G-1-b above.

The entity that is responsible for evaluating reports and how reports are evaluated.
The Bureau of Participant Operations (BPO) is responsible for evaluating incident reports to ensure that the provider took prompt action to protect the participant's health and welfare. This may include, but is not limited to calling 911, seeking the assistance of law enforcement, arranging medical care, or referring to a victim's assistance program. OLTL also ensures that the provider meets the additional reporting requirements of the Department of Aging's Older Adult Protective Services Act (6 PA Code Chapter 15), the Department of Human Services' Adult Protective Services Act (Act of October 7, 2010, P.L. 484, No. 70) or the Department of Health when applicable.

OLTL supervisory staff reviews each incident as documented by the reporter to ensure that the report is complete. If OLTL determines an additional objective investigation is required due to conflict of interest, an OLTL staff member is assigned to complete the investigation and develop corrective action. Once all information is gathered, an OLTL supervisor reviews the incident, works with the Service Coordinator and/or Direct Service provider to ensure the health and welfare of the participant. The incident is closed in EIM when all appropriate actions are taken according to the specifics of the incident and when the participant's health and welfare have been

ensured.

The entity that is responsible for conducting investigations and how investigations are conducted.
The Service Coordinator is responsible for conducting an investigation The Service Coordination Entity has two (2) days to provide initial information to OLTL in cases involving sexual abuse, serious injury, serious bodily injury or suspicious death, and 30 days from the initial report to provide all the information regarding the incident to OLTL.

If the incident meets the standards of 6 PA Code Chapter 15 or the Act of Oct. 7, 2010, P.L. 484, No. 70, reporting to the appropriate protective services helpline must be done within required timeframes.

Critical Incident investigations that are performed by the Service Coordination Entities include :
- Onsite investigation – An onsite in-person 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.
- 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 is required when the incident report meets all three of the following conditions:
1) The facts and sequences of events is outlined with sufficient detail; and
2) Preventative action through the service plan is implemented and documented; and
3) The participant is not placed at any additional risk.

Service Coordinators are required to:
- Take necessary actions to ensure the health and welfare of the participant
- Follow up with the direct service provider to ensure all appropriate actions have been taken.
- Complete an incident report and submit to OLTL via EIM within the timeframes outlined in the OLTL Incident Management Policy if not already submitted by direct service provider.
- Conduct an investigation of the incident to determine specifics of the incident which include: Fact finding, identify the sequence of events, identify potential causes, and assess service planning to determine any needed changes and documentation.
- Provide a final report to OLTL within 30 business days of the occurrence. When unable to conclude initial investigation within 30 days, request an extension from OLTL through EIM.

All allegations of abuse, neglect and exploitation are reported to the Bureau of Participant Operations staff, who works directly with the participant's Service Coordinator for possible further investigation and coordination with the protective services worker. In cases investigated under protective services, the Service Coordinator works with the protective services worker to ensure the health and welfare of the participant, and revises the service plan, as necessary, to meet the participants' needs and to mitigate the allegations when appropriate.

In cases where regulatory compliance or failure to effectively safeguard the participant is identified in the investigation, OLTL will conduct an on-site review of the Service Coordination Entity or direct service provider to audit agency procedures and make corrective recommendations resulting in a Statement of Findings.

The timeframes for conducting an investigation and completing an investigation.
The investigation of all critical incidents must be completed within 30 days of receiving the incident report. If the timeframe is not met the details regarding the delay will be documented in EIM. OLTL reviews and approves extension requests and closely monitors any investigative process that is taking beyond the allotted time for completion.

Within 48 hours of the conclusion of the critical incident investigation, participants must be informed of the outcome of investigations. The Service Coordinator is responsible for conveying this information to the participant.

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.

OLTL is responsible for providing oversight of Critical Incidents and events. OLTL staff from BQPM and BPO work together to address critical incidents. BQPM staff reviews reports generated in EIM to track and trend critical incidents. BPO staff work with Service Coordination Entities and direct service providers to assure that participant health and welfare is protected. Together, these two bureaus discuss trends to identify systemic weaknesses or problems with individual providers.

The findings and quality improvement recommendations are shared with OLTL's Executive and Management staff at the monthly Quality Management Meetings (QM2) and the Quality Council Meetings, which are held three times a year. The QM2 and Quality Council make recommendations to the Director of the BQPM who presents them to the OLTL Deputy Secretary.

Additional Agencies responsible for oversight include the Department of Aging and DHS' Adult Protective Services office and the Department of Health. The Department of Health has licensure requirements regarding reporting of incidents and conduct annual licensure of all Home Health and Home Care entities.

The Department of Aging maintains a statewide database on all participants who were referred to the Protective Service Unit for investigation of allegations of abuse, neglect, exploitation and abandonment and oversees the Older Adults Protective Services program. The Department of Human Services has procured an Adult Protect Services vendor that is responsible for receiving and investigating reports of suspected abuse, neglect, abandonment and exploitation for adults with disabilities between the ages of 18 and 59. .

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints *(select one):*

●	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:
	At time of enrollment, the IEB informs participants of the prohibition on the use of restraints, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of restraints with the participant. As part of the participant informational materials, participants are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of restraints. The Office of Long Term Living is notified about unauthorized use of restraints through the Service Coordination Entities and participants. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions

	are taken, including notification of the local law enforcement agency. To assist in the detection of the unauthorized use of restraints, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of restraints. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.
○	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 or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Title 55 PA. Code Chapter 52 prohibits the restraint of a participant. Sanctions are available to the OLTL for non-compliance.

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:

This requirement is monitored during onsite provider monitoring activities by the Quality Management Efficiency Teams.

b. Use of Restrictive Interventions

●	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:
	At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of restrictive interventions with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of restrictive interventions. The Office of Long-Term Living is notified about unauthorized use of restrictive interventions through the Service Coordination Entities and participants. Once a complaint has been filed, it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of restrictive interventions, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of restrictive interventions. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.
○	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-a-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.

Title 55 PA. Code Chapter 52 prohibits the use of restrictive interventions. Sanctions are available to the OLTL for non-compliance.

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:

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

c. Use of Seclusion *(select one):*

●	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:
	At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of seclusion with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of seclusion. The Office of Long-Term Living is notified about unauthorized use of seclusion through the Service Coordination Entities and participants. Once a complaint has been filed, it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of seclusion, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of seclusion. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.
○	The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of 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:

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

Appendix G-3: Medication Management and Administration

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:

●	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not 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.

Healthcare practitioners are the primary entity that has ongoing responsibility for monitoring participant medication regimens. As the professionals who prescribe the medications, they ensure that the medication regimen meets the participant's diagnosed condition, that none of the medications conflict and that the doses are prescribed correctly.

Medication monitoring also occurs through the development of the participant's ISP and Service Coordinator review of the participant's services and during each face-to-face monitoring visit. As outlined in C-3, Service Coordination Entities must have Registered Nurse (RN) consulting services available, either through a staffing arrangement or through a contracted consulting agency. RNs may provide assistance in reviewing medication regimens for individuals during face-to-face monitoring visits. Service Coordinators can also use the OLTL regional team staff for support with regard to questions about medications. Regional teams have access to nurses and the OLTL Medical Director to help with questions about medications.

The Department of Human Services, Bureau of Human Services Licensing, monitors and licenses licensed Residential Habilitation providers on an annual basis. Medication s in licensed settings is governed under the following authority: 55 PA Code, Chapter 2600, §2600.181 through §2600.191. The OLTL QMETs review both licensed and unlicensed settings on a biennial basis to ensure providers have the appropriate licensure and, in unlicensed settings, to ensure compliance with the OLTL "Medication Management Policy for Unlicensed Providers" Bulletin. Monitoring authority for the requirements enumerated in this bulletin is provided by 55 Pa. Code § 52.22 (4)(relating to provider monitoring). Providers shall produce documentation on medication management and administration as requested by the Department

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.

OLTL uses the DPWDHS Medication Administration Program to teach unlicensed staff to give medication to participants using a standard curriculum. Many of the provider agencies have nurses who become trainers and monitor medication through the course, while others provide oversight within the agency for medication administration and health issues. The course requires periodic reviews of staff performance to maintain certification. These include reviews of Medication Administration Records or logs for each staff member administering medications. The review of medication administration logs for errors in documentation includes matching the participant's prescribed medications on the log to those available to be given. Maintenance of certification requires review of four (4) Medication Administration Records and two (2) observations of passing medication and documentation. Providers are to use Medication Administration Records from different participants when completing the

reviews so that each of the participants' medication regimens are reviewed across the year. As well the course also teaches staff to review medication when it is received from the pharmacy and compare it to the Medication Administration Records, thus providing a regular review of medications by provider staff. Part of the documentation and checks include looking at medication allergies for the possibility of a contraindicated drug.
Providers administering medications are required to have a Medication Protocol in place that details the staff that have been trained and/or are licensed to administer medication, and ensures that providers have trained or licensed staff is on duty when individuals need medication administered. The Medication Management Protocol will also detail how the provider monitors medication administration on a daily basis.

Despite the Department's extensive medications administration course, medication errors do sometimes occur. Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as outlined in Appendix G-1-b. If the medication error is the result of a critical incident, such as neglect, or results in a critical incident, such as death, then it is not reported as a medication error, but rather as the higher level critical incident, which is then subject to Service Coordinator investigation and review.

Documentation of medication errors and the prescriber's response must be kept in the participant's record. Providers are required to have a system in place to identify and document medication errors and the pattern of error. Providers must also document follow-up actions that have been taken to prevent future medication errors. Finally, providers are also required to educate participants of their right to question or refuse medication if the participant believes there may be a medication error. Documentation of this individual education must be kept in the participant's file.

If a participant experiences a suspected adverse reaction to a medication, the provider is required to immediately consult a physician or seek emergency medical treatment. Adverse reactions, the prescriber's response and any actions taken are documented in the participant's record.

The Department of Human Services, Bureau of Human Services Licensing (BHSL), monitors licensed Residential Habilitation providers compliance with 55 PA Code, Chapter 2600, §2600.181 through §2600.191on an annual basis, and is responsible for oversight and follow-up when licensed providers exhibit noncompliance.

OLTL monitors unlicensed Residential Habilitation provider's recorded and reportable medication errors to determine what medication administration and management problems are occurring for Residential Habilitation Service providers. Providers who have a high number of medication errors will be retrained and medication administration will be included in the QMET's statement of findings OLTL will issue a Statement of Findings to those providers who have a high number of medication errors. The provider will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

●	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)*
○	Not applicable (*do not 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).

Medication Administration by Licensed Residential Habilitation Providers:
Personal Care Home regulations, 55 PA Code, Chapter 2600, apply when participants receive Residential Habilitation Services in licensed settings. These regulations allow for the administration of medication by unlicensed staff when trained using the DPW-approved medications administration course. The current medications administration course requires the review of medication administration logs for errors in documentation including matching the person's prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff is not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self-administration guidelines also appear in the regulations, and setting up and monitoring self-administration programs are taught as part of the medication administration program. Personal Care Homes are licensed by the DHS, Bureau of Human Services Licensing, on an annual basis. These requirements do not apply to non-licensed providers.

Medication Administration by Unlicensed Residential Habilitation Providers:
Unlicensed Residential Habilitation providers are required to follow- OLTL's "Medication Management Policy for Unlicensed Providers Bulletin", which clarifies when a participant is expected to self-administer, receive assistance with medication administration, and the training required for provider staff to administer medication.

Self-Administration.
(a) A provider shall assist individuals, as needed, with medication prescribed for the individual's self-administration. This assistance includes helping the individual to remember the schedule for taking the medication, storing the medication in a secure place and offering the individual the medication at the prescribed times.

(b) If assistance includes helping the individual to remember the schedule for taking the medication, the individual shall be reminded of the prescribed schedule.

(c) The individual's service plan shall identify if the individual is able to self-administer medications. An individual who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

(d) If the individual does not need assistance with medication, medication may be stored in an individual's room for self-administration. Medications stored in the individual's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

(e) To be considered capable to self-administer medications, an individual shall:

(1) Be able to recognize and distinguish his medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(f) The individual's record kept by the provider shall include a current list of prescriptions, Complementary and Alternative Medications (CAM) and Over the Counter (OTC) medications for each individual who is self-administering medication.

Medication Administration:
(a) A provider may provide medication administration services for an individual who is assessed to need medication administration services and for an individual who chooses not to

self-administer medications in accordance with an assessment done by a physician and documented on the individual's service plan.

(b) Prescription medication that is not self-administered shall be administered by one of the following:

(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the setting in which the medication is administered.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the setting the medication is administered.

(4) A staff person who has completed the DPW-approved medication administration training for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Medication Administration Training

(a) Pursuant to 55 Pa. Code § 52.14(t) (relating to ongoing responsibilities of providers), providers are required to participate in Department-mandated trainings. A provider who chooses to provide medication administration services for an individual who is assessed to need medication administration services in accordance with an assessment referenced above must participate in an OLTL-approved medications administration course.

(b) For the purposes of this bulletin, an OLTL-approved medications administration course refers to the Department of Human Services Office of Developmental Program's training program. Information on this training program is found by calling 1-800-438-1958 or by going to: http://www.dhs.state.pa.us/provider/training/medicationadministration/index.htm

(c) A staff person who has successfully completed the Office of Long-Term Living (OLTL)-approved medications administration course that includes the passing of the OLTL-approved performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

(d) A staff person is permitted to administer insulin injections following successful completion of an OLTL-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of an OLTL-approved diabetes patient education program within the past 12 months.

(e) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

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:
	Providers are required to immediately report medication errors to the participant, the

	participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin. EIM is accessible to the state, Service Coordinators and providers.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers record medication errors which include: failure to administer a medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer a medication at the prescribed time, administration to the wrong person, and administration through the wrong route..
	(c) Specify the types of medication errors that providers must *report* to the State:
	. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin.
○	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.

OLTL monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3-b-i, direct monitoring occurs through annual DPW licensing reviews of licensed Residential Habilitation providers and QMET biennial monitoring reviews of unlicensed Residential Habilitation providers. In addition, direct monitoring occurs as part of the Service Coordinator's face-to-face monitoring visits with participants.

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.

dix 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 Bureau of Quality and Provider Management (BQPM) in the Office of Long Term Living (OLTL) is responsible for developing and maintaining the Quality Improvement Strategy (QIS).

The OLTL developed a QIS for Home and Community Based Services (HCBS) Waivers to measure performance regarding service provision and to ensure the health and safety of participants. The QIS uses the quality management functions of discovery; remediation and improvement to identify and recommend systems improvements.

The Division of Quality Assurance in BQPM is responsible for collecting discovery and remediation information, analyzing that information, recommending system improvements and analyzing the effectiveness of the improvement initiatives. This Division is comprised of the Quality Management Unit

(QMU) and the Quality Management and Efficiency Teams (QMET). The functions of the Division of Quality Assurance are:

- To conduct quality monitoring of long term living programs and services to ensure compliance with federal and state regulations and the 6 waiver assurances
- To conduct provider monitoring to align with the 6 assurances to gather accurate data to determine compliance
- To compile reports for on data for the 6 assurances to measure the effectives of program design and suggest improvement initiatives
- To use data to support the development and implementation of policies and protocols to insure quality program outcomes
- To develop and implement training and technical assistance for staff, providers and participants to insure quality service delivery
- To convene a Technical Assistance Workgroup comprised of OLTL staff to insure consistent policy communication to providers and staff
- To collaborate with other bureaus in the OLTL, external stakeholders, other state agencies and the Quality Council to effectively implement this QIS
- To recommend strategies for continuous quality improvement
- To maximize the quality of life, functional independence, health and welfare and satisfaction of participants in OLTL waivers

The following reports are used to collect data which is then analyzed by the QMU to implement the QIS. The frequency of data compilation is indicated after each report. Each of the reports listed below was specifically designed to collect the data needed to assure compliance. The QMU works with various other bureaus and divisions in the OLTL to ensure the reports and data collected are valid and being set up and compiled correctly. The reports are monitored to determine possible causes of aberrant data and compliance issues.

Administrative Authority Assurance:

- Level of Care Determination Report - Quarterly
- Independent Enrollment Broker Contractual Obligation Report for Area Agencies on Aging - Quarterly
- Initial and Annual Level of Care Report -

Quarterly Qualified Provider Assurance:

- Qualified Provider Report - Quarterly
- Initial Provider Enrollment Report -

Quarterly Service Plan Assurance:

- Service Plan Assurance Data Report - Monthly
- Participant Satisfaction Survey Results – 3 times per year
- QMET Report on Service Delivery - Quarterly
- Enterprise Incident Management (EIM) Report on Complaints -

Monthly/On Demand Health and Welfare Assurance:

- Three EIM Reports on Complaints and Incidents – Monthly/On Demand
- Participant Satisfaction Survey Reports – 3

times per year Financial Accountability Assurance

- Onsite Paid Claims Report - Quarterly
- PROMISe Paid Claims Report - Monthly
- FEA Deliverable Report - Monthly

The reports obtained are reviewed by Quality Management Liaisons (QML) in the QMU. Data is analyzed and reviewed for each assurance. When areas of low compliance are identified, strategies to mitigate the non-compliance are discussed first with the Unit Supervisor, then Division Director and subsequently at the Quality Management Meeting with representatives from each bureau in OLTL in attendance. At that meeting, each member of the group suggests and discusses ideas to increase compliance with the particular assurance previously identified as problematic. An agreement is reached on a plan to roll out to involved entities, such as providers or contracted entities. The bureau responsible for the entity is directed to implement the plan and follow up for technical assistance. Compliance with the assurance is then monitored closely to insure the compliance rate increases. If this is not the case, the process begins again until the compliance rate increases to the acceptable level.

Also part of the QIS is the Quality Council. The Quality Council meets quarterly is comprised of internal and external stakeholders who are presented with issues regarding non-compliance and make recommendations for change.

Quality information is reported to agencies, waiver providers, participants, families and other interested parties in several ways.

The OLTL distributes information 4 times per year at the Quality Management Meeting. After discussion, at the Quality Management Meeting, the data is presented at the Quality Council Meeting quarterly. Quality information is also presented at the Department of Human Services (DHS) Medical Assistance Advisory Committee Meetings as requested. These meetings involve DHS and stakeholders. The OLTL also provides data as requested to providers,

participants and other parties. Results from the Participant Satisfaction Survey are posted on the DHS website 3 times per year. Results from provider monitoring are communicated to providers as soon as possible after the monitoring takes place.

ii. **System Improvement Activities**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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.

Summarized below are the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each assurance.

1. The QML for each of the assurances reviews the data collected to determine compliance issues.
2. The data collected is aggregated for tracking and trending.
3. The QML makes initial recommendations and prioritizes issues for problem solving and corrective measures to the Unit Supervisor.
4. The Unit Supervisor reviews the recommendations and presents the issue to the Division Director.
5. Issues are then placed on the agenda for the Quality Management Meeting and the Quality Council Meeting.
6. At the Quality Management Meeting and the Quality Council Meeting, issues and data are presented to the members.
7. Recommendations are made to remediate the issue.
8. The Director of the BQPM makes the decision on which plan will be used to remediate.
9. The appropriate bureau implements the plan with the responsible entity and provides technical assistance to implement the plan.
10. The QML insures that the plan was successful by reviewing the compliance data following implementation of the plan.
11. The QML reports on the remediation of the issue at Quality Management Meetings.

This process outlines the OLTL QIS. The QIS is reviewed at each Quality Management meeting (quarterly) to insure the QIS is working and on target.

The roles and responsibilities are as follows:

QML

- Identify and collect needed data
- Insure that data from reports is valid and accurate captures compliance with the 6 assurances
- Aggregate, review and analyze data to identify issues and trends
- Identify compliance issues
- Look for aberrant data and determine causes
- Make initial recommendations for problem solving, corrective measures and system changes
- Follow up on effectiveness of remediation plan and recommend alternatives if plan is not achieving desired result of reducing non-compliance
- Develop mandatory training for Service Coordinators on Assurances Unit Supervisor and Division Director
- Review QML issues and recommendations for inclusion in Quality Management and Quality Council Meetings

• Maintain an Issues Chart to track progress on remediation and system changes and insure the issue is resolved and non- compliance is reduced
• Hold monthly meetings with other OLTL Directors to discuss trends and plans to correct quality issues. Representatives from OLTL Bureaus and Quality Council Members:
• Attend meetings
• Make recommendations and suggestions to remediate issues and system changes
• Review recommendations made by QML
• Monitor follow up and results BQPM Director
• Make final decision on plan to be followed to remediate issues

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

The process to continuously assess the effectiveness of this QIS and revise as necessary is as follows:

• Two years after the waiver renewal date, a Quality Management Meeting will be held with the sole purpose of looking at the QIS and evaluating the effectiveness of the strategy.
• Prior to submission of the Evidentiary Based Review for the waiver renewal, another Quality Management Meeting will be held for the same purpose.

• Independent persons not associated with OLTL will be invited to access the effectiveness of the strategy.
• The Issues Chart will be made available along with a summary of the steps taken to resolve the issues.
• The Independent Reviewer will access and make recommendations for change.

• Annually a Quality Management Meeting will be dedicated for review of the Issues Chart and recommendations for change.

The Quality Improvement System outlined also applies to the Aging (control number 0279), Attendant Care (control number 0277), Independence (control number 0319), CommCare (control number 0386) and AIDS (control number 0192)

waivers. With this amendment application for the OBRA Waiver, OLTL will have met our intent to incorporate all of OLTL's 1915 (c) waivers into this Quality Improvement Strategy. The discovery and remediation data gathered during the implementation of the 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 of each waiver.

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 applic icable, performance measures should focus on

- ment/execution of provider agreements raphic 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 measur rmation 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 AAAs that meet waiver obligations regarding initial level of care determinations Numerator: Total number of AAAs who meet contractual obligations regarding initial level of care determination Denominator: Total number of AAAs reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Resp analy gation and	**Frequency of data aggrega** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:

Number and percent of Service Coordination agencies that meet waiver obligations regarding ongoing level of care determinations Numerator: Total number of SCAs who meet contractual obligation regarding ongoing level of care determination Denominator: Total number of SCAs reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ S	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify:

Performance Measure:
Number and percent of contractual obligations met by the Independent Enrollment Broker Numerator: Total number of contractual obligations that were met by the IEB Denominator: Total number of contractual obligations of the IEB

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Perfo
Numl **et by the FEA. Numerator: Number of contractual obligations that were met by F/EA. Denominator: Total number of contractual obligations of the FEA**

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of contractual obligations met by the FEA regarding the execution of Medicaid provider agreements. Numerator: Total number of contractual obligations that were met by the FEA Denominator Total number of contractual obligations of the FEA

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider will be reviewed every two years, at minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application.

The Bureau of Quality & Provider Management (BQPM) reviews AAAs regarding the initial LOC, reevaluations of LOC, F/EA and enrollment functions. The BQPM uses standard monitoring tools which outline the provider requirements as listed in the waiver and the Fiscal/Employer Agent (F/EA) contract, including LOC determination, F/EA, and enrollment functions. The BQPM verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum.

For information regarding the Bureau of Quality and Provider Management (BQPM), 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 administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written notification of outstanding issues with a request for a Corrective Action Plan (CAP). The CAP is due to the QMET within 15 working

days. BQPM staff reviews and accepts/rejects the CAP within 30 working days. Monitoring by the QMET 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. If the CAP was not successful in correcting the identified issue, technical assistance is provided by BQPM.

Through a combination of reports from the enrollment broker and administrative data, the Contract Monitor for the Independent Enrollment Broker (IEB) determines if the contractual obligations are being met. If they are not met, Bureau of Participant Operations (BPO) notifies the IEB agency of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.

Through a combination of reports from the F/EA and administrative data, the Contract Monitor for the Fiscal/Employer Agent

determines if the contractual obligations are being met. If they are not met, BPO notifies the F/EA of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.

ii. **Remediation Data Aggregation**

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

dix 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.

Perfo

Number and percent of all new enrollees who have level of care determination, prior to receipt of waiver services Numerator: Total number of all new enrollees who have level of care

determination, prior to receipt of waiver services Denominator: Total Number of all new enrollees

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Twice a year

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.

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 timeliness and specifications
Numerator: Total number of initial LOC determinations, that adhered to timeliness and

specifications Denominator: Total number of initial LOC determinations

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
Number and percent of annual LOC reevaluations that adhered to timeliness and specifications
Numerator: Total number of annual LOC reevaluations that adhered to timeliness and specifications Denominator: Total number of annual LOC reevaluations

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ Specify:	☐ **Annually**	☐ Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Level of Care Sub-assurances are monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. The Bureau of Quality & Provider Management is responsible for review and analysis of the report information. Reports are received from case management systems and from a compilation of the results of retrospective service plan reviews. The LOC

Assurance Liaison, within OLTL's BQPM, regularly reviews reports on a semi-annual basis regarding the completion of initial level of care prior to the receipt of waiver services. Quarterly reports are reviewed for compliance with waiver standards with processes and instruments for initial LOC. Monthly reports from the Service Plan retrospective review database are reviewed by the LOC Liaison regarding the timeliness of LOC reevaluations. See Appendix D for more information about retrospective service plan reviews and Appendix H for more information about Assurance Liaisons.

Additional information on the Bureau of Quality & Provider Management (BQPM) 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.
If the BQPM's review of LOC data in the case management or Retrospective Service Plan Review tracking systems identifies non-compliance regarding the timeliness or specifications of initial or annual LOC reassessments, a Quality Improvement Plan (QIP) is requested from BPO. More information on QIPs can be found in Appendix H.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 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 waiver providers who meet required licensure and initial QP standards prior to service provision Numerator: Total number of waiver providers meeting required licensure and initial QP standards prior to service provision Denominator: Total number of new waiver provider applicants

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers continuing to meet applicable licensure/certification waiver standards following initial enrollment Numerator: Total number of providers continuing to meet applicable licensure/certification waiver standards following initial enrollment Denominator: Total number of providers reviewed

Data collection/generation (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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 non-licensed/non-certified waiver initial QP standards prior to service provision Numerator: Total number of non-licensed/non-certified providers meeting initial QP standards prior to service provision Denominator: Total number of new waiver non-licensed/non-certified provider applicants

Data

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

☐ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Numb ensed/non-certified providers who contin provi tor: Total number of non-licensed/non-ce continuing to meet applicable waiver standards following initial enrollment Denominator: Total number of non-licensed/non-certified providers reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

☐ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of contractual obligations met by the F/EA Numerator: Total number of contractual obligations met by the F/EA Denominator: Total number of contractual obligations of the F/EA

Data Source (Select one):
Other

If 'Other' is selected, specify:

Provider Monitoring

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5%
☐		☐ **Stratified** Describe Group:

☐ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifyi ing 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 ea rovide information on the aggregated data t te 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 Numerator: Total number of providers meeting provider training requirements Denominator: Total number of providers reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

i. 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 OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal Representatives. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator.

The Quality Management Efficiency Teams (QMETs) monitor the HCBS Waiver providers on a biennial basis. The QMET utilizes a standardized monitoring tool for each monitoring, and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code and the provider requirements of the established, approved waivers. QMET also reviews if the provider has the appropriate licensure as required by the waiver. QMET reviews each provider at a 95% accuracy rating for each waiver in which the provider is enrolled.

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 a.i.a - Before a provider is enrolled as a qualified waiver provider, it must provide written documentation to the State 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 regulatory and 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 issues a Statement of Findings as required by 55 Pa. Code Chapter 52. The provider is required to respond to the findings with a Corrective Action Plan (CAP) to remediate each finding. If a provider fails to submit a CAP which remediates the lack of licensure or certification requirement, OLTL begins disenrollment proceedings. The provider has the right to appeal.

Sub assurance a.i.b- Upon application, OLTL reviews verification submitted by providers who are not required to receive a license or certification in order to provide services. OLTL verifies each provider meets the established regulations and criteria to be a qualified waiver provider. If a provider does not meet one or more of the waiver qualifications, OLTL notifies the provider of the unmet qualifications and provide information on available resources the provider can access to improve or develop internal systems to meet required provider qualifications. If a provider is unable to meet qualifications, the application to provide waiver services is denied. The provider may reapply with OLTL if verification is obtained.

Within two years of becoming a waiver provider (and every two years thereafter), OLTL conducts a provider monitoring of each waiver provider to ascertain whether they continue to meet the regulatory requirements and provider qualifications, including training, outlined in this waiver. The Quality Management Efficiency Teams (QMETs) are the monitoring agent for OLTL. The QMET monitoring tool and database outlines each qualification a provider must meet. The qualifications are categorized according to provider type. Provider type is defined as the service(s) the provider offers to waiver participants as outlined in the service definition. The QMET monitoring tool and database collects the information discovered by the QMETs during reviews for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider develops a Corrective Action Plan (CAP). The provider needs to demonstrate through the CAP that it can meet the regulations and waiver provider qualifications and develop a process on how to continue compliance in the future. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves (or disapproves) the CAP within 30 business days of submission.

The QMET verifies the approved CAP action steps are in place according to the timeframe as written the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.

Sub assurance a.i.c- The QMET monitoring tool ascertains if the provider has completed training in accordance with regulations and waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that

providers fulfill training requirements in accordance with state and waiver requirements. If a provider has not met training requirements, the provider is required to submit a CAP. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves the CAP within 30 business days of submission. The QMET verifies the CAP action steps are in place according to the timeframe as written in the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.

ii. **Remediation Data Aggregation**

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

lix 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 with ISPs adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment Numerator: Total number of waiver participants with ISPs adequate and appropriate to their needs, capabilities, and desired outcomes according to the assessment Denominator: Total number of waiver participants who had ISPs reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐

Performance Measure:
Number and percent of waiver participant satisfaction survey respondents who reported unmet need/needs Numerator: Total number of participants reporting unmet needs in returned surveys. Denominator: Total number of returned surveys with yes or no answers

Data Source (Select one):
Other

If 'Other' is selected, specify:

Returned Surveys

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval
☐ **Other**	☑ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Three times 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Three times a year

Performance Measure:
Number and percent of waiver participants with service plans that address the participant's goals as indicated in the assessment Numerator: Total number of waiver participants with ISPs that addressed participant goals. Denominator: Total number of waiver participants who had ISPs reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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 Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date Numerator: Total number of ISPs that were reviewed and/or revised before the annual review date Denominator: Total number of ISPs reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants reviewed whose Individual Service Plans (ISPs) was revised as needed, to address changing needs Numerator: Total number of waiver participants who had ISPs that were revised as needed to address changing needs Denominator: Total number of waiver participants reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 participants who received authorized services in the type, scope, amount, frequency and duration specified in the Individual Service Plan Numerator: Total number of participants who received services in the type, amount and frequency specified in the ISP Denominator: Total number of participants reviewed

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of waiver providers who delivered services in the type, scope, amount, frequency, and duration specified in the Individual Service Plan (ISP). Numerator: Total number of reviewed providers who delivered services in the type, amount and frequency specified in the ISP. Denominator: Total number of providers reviewed.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of waiver participant satisfaction survey respondents reporting the receipt of all services in Individual Service Plan (ISP) Numerator: Total number of returned surveys reporting receipt of all services in ISP Denominator: Total number of returned surveys with yes or no answers

Data Source (Select one):
Other

If 'Other' is selected, specify:

Returned Surveys

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):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval
☐ Other	☑ Annually	☐ Stratified
	☐ Continuously and Ongoing	☐ Other Specify:
	☑ Other Specify: Three times 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):*
☑ State Medicaid Agency	☐ Weekly

☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Three times a year

Performance Measure:
Number and percent of complaints received regarding non-receipt of services Numerator: Total number of complaints regarding non-receipt of services Denominator: Total number of complaints

Data Source (Select one):
Other

If 'Other' is selected, specify:

Complaint Database

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** 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 appropriately completed and signed freedom of choice forms that specifies choice was offered between institutional care and waiver services Numerator: Total number of waiver participants who had records that contained completed and signed Freedom of Choice Forms Denominator: Total number of waiver participants

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other**

☐ **Other**
Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator: Total number of waiver participants who had reviewed ISPs that documented an opportunity for choice of waiver providers and services was provided. Denominator: Total number of waiver participants who had ISPs reviewed.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other**
	☐ **Other**	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

i. 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.

At the Service Coordination Agency, the SC supervisor reviews the ISP for completeness and appropriateness prior to submitting the ISP to the Bureau of Individual Support (BIS) for approval. The supervisor is the first step in the monitoring process.

BPO staff reviews 100% of new ISPs and 100% of ISPs that have a 10% change in services using the guidelines specified in the OLTL Service Plan Review Protocol. This ongoing review is collected in the Service Plan Review Database where the data is aggregated monthly and quarterly for tracking and trending by the Service Plan (SP) Assurance Liaison in the Bureau of Quality and Provider Management (BQPM) The SP Assurance Liaison tracks the sample size to ensure a statistically valid sample using CMS sampling parameters has been reviewed The SP Assurance Liaison also performs a quarterly retrospective review of the ISPs reviewed by BPO in the previous three months using the same review criteria.

Data is pulled from the OLTL Complaint Database regarding complaints received about service plans. The SP Assurance Liaison monitors a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement.

The SP Assurance Liaison reviews data from the OLTL participant satisfaction surveys for questions # 12 and 13 for both New and Annual surveys, pertaining to participant's needs and goals, and delivery of services. 100% of returned surveys responses are monitored and aggregated three times per year.

Quarterly, the OLTL conducts a representative sample review of participants' authorized services and claims to determine if participants are receiving services in the type, amount and frequency specified in the ISP.

See Appendix H for more information on BQPM.

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 ISPs are reviewed for compliance and non-compliance is noted, BQPM issues a Quality Improvement Plan (QIP) to the

BPO to address the non-compliance. The BPO submits a plan to correct the non-compliance to BQPM within the prescribed timeframes. As part of the QIP, BPO may contact the SC agency to remediate and follow-up on the issue. The BPO may also provide technical assistance to aid in that remediation.

Complaints regarding non-receipt of service are addressed in EIM processing, and if classified as Urgent, have a timeframe of one day for investigation initiation. See Appendix F for more information on complaint processing.

ISPs are reviewed for compliance, and any individual issues are addressed as soon as they are discovered. If issues are identified during the review, immediate remediation is undertaken. The specific problem (individual) is addressed right away through contact with the SC agency. This action will include steps needed to ensure that the individual's ISP is correctly developed, and may also include technical assistance to the provider to both address the individual issue and to prevent future issues. Immediate attention, as warranted by the circumstances, is undertaken (and overseen by OLTL through BPO in collaboration with BQPM) to ensure that individual health and welfare is assured. For all other discovered issues, the CAP process is used.

Please see Appendix H for more information on Assurance Liaisons and QIPs.

If, through tracking and trending it is discovered that a specific provider has multiple deficiencies, the Quality Management Efficiency Team (QMET) is alerted. The QMET pulls a random sample of the provider's records and reviews the ISPs to verify they meet participant needs adequately and appropriately. If the sample reveals a provider wide deficiency in developing an ISP which meets the sub assurances, the provider must complete a Corrective Action Plan (CAP) within 15 business days. OLTL reviews and approves the CAP within 30 business days of submission. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP.

If the New or Annual Participant Satisfaction Survey responses indicate that waiver participants have unmet needs, the BQPM 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*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 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 and percent of New Waiver participants, responding to the Satisfaction Survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Numerator: Total number of New Waiver participants, responding to Satisfaction Survey, who indicate knowledge of how to report (ANE) Denominator: Total number of New Waiver participants who responded to survey

Data Source (Select one):
Other

If 'Other' is selected, specify:

Returned Surveys

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Three times 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

☐ **Continuously and Ongoing**

☑ **Other** Specify: Three times a year

Performance Measure:
Number and percent of Annual Waiver participants, responding to the Satisfaction Survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Numerator: Total number of Annual Waiver participants, responding to Satisfaction Survey, indicating knowledge of how to report ANE Denominator: Total number of Annual Waiver participants who responded to survey

Data Source (Select one):
Other

If 'Other' is selected, specify:

Returned Surveys

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval
☐ **Other**	☑ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Number and percent of Urgent complaints with investigation initiated within the required timeframe [one (1) business day)] Numerator: Total number of Urgent complaints with investigation initiated within the required timeframe [one (1) business day] Denominator: Total number of Urgent complaints

Data Source (Select one):
Other

If 'Other' is selected, specify:

Complaint Database

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval
☐ **Other**	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:

Number and percent of Non–Urgent complaints with investigation initiated within the required timeframe [five (5) business days] Numerator: Total number of Non–Urgent complaints with investigation initiated within the required timeframe [five (5) business days] Denominator: Total number of Non–Urgent complaints

Data Source (Select one):
Other

If 'Other' is selected, specify:

Complaint Database

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ Describe Group:
	☐ **Continuously and Ongoing**	☐ Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

Appendix I: Financial Accountability

APPENDIX 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 following are the audit and financial review requirements to ensure the financial integrity of the waiver program as specified in PA Code §52.43 Audit Requirements:

The following are the audit and financial review requirements to ensure the financial integrity of the waiver program as specified in PA Code §52.43 Audit Requirements:

1. Providers shall comply with the Federal audit requirements as specified in Section 74.26 of 45 CFR (relating to non-Federal audits).

2. Providers who meet certain thresholds as specified in OMB Circular A-133, as revised, and the Department of Human Services' (DHS) Annual Single Audit Supplemental Publication are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502, as amended, and to complete DHS's annual Single Audit Supplement publication.

3. Providers who which are not required to comply with the Singe Audit Act of 1984 during any program year shall maintain auditable records in compliance with PA Code §52.43.

4. DHS may request that a provider have the provider's auditor perform an attestation engagement; DHS or DHS's designee may perform an attestation engagement; or DHS may request that the provider's auditor conduct a performance audit in accordance with the following:
a) Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards.
b) Standards issued by the Auditing Standards Board.
c) Standards issued by the American Institute of Certified Public Accountants.
d) Standards issued by the International Auditing and Assurance Standards Board.
e) Standards issued by the Public Company Accounting Oversight Board.
f) Standards of successor organizations to those organizations in paragraphs a. through e. above.

In all cases, providers must retain auditable records for at least 5 years from the provider's fiscal year-end. If the provider has a settlement of claims as a result of litigation, then the provider must retain auditable records 5 years from the end date of the litigation or 5 years from the provider's fiscal year-end, whichever is greater. Additionally, the provider must retain records beyond the 5 year period DHS or another State or Federal agency has unresolved questions regarding costs or activities of the provider.

Payments to providers are also controlled by edits built into the Commonwealth's MMIS system known as PROMISe. Claims for services are matched against the eligibility system (CIS) so that payments are not made for recipients that have not been approved for Medicaid and for the waiver. Additionally, the PROMISe system will not pay claims if a participant does not have either the service or the provider included in the approved service plan for the recipient in the HCSIS system.

The Office of Long Term Living's (OLTL), Quality Management Efficiency Teams (QMET) conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. In order to conduct these post payment reviews, the QMET's review PROMISe claims reports against provider's time sheets, paid invoices and other sources provided to verify accuracy of services rendered.

Depending on the findings of the QMET reviews, remediation may include:

- Suspending claims pending review prior to payment
- Review of provider's records
- Review of provider's written billing policies/procedures.
- Sanctions, prohibition or disenrollment from providing services.
- Prohibition from serving new participants
- Provider refund of inappropriately billed amounts

Providers may also be selected for a GAGAS performance audit by the DHS Bureau of Financial Operations.

If issues of financial fraud and abuse are suspected, OLTL through the DHS Office of General Counsel (OGC) will refer such issues to the DHS Office of Medical Assistance Programs (OMAP), Bureau of Program Integrity (BPI) for review, investigation, and appropriate action.

APPENDIX I-2: Rates, Billing and Claims

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).

Medical Assistance Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definitions, a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in Department standards and a review of cost data as supplied from providers. The fee schedule rates represent the maximum rates that DHS will pay for each service. In developing rates for each of the MA fee schedule services, the following occurs:

- OLTL evaluates various independent data sources such as Pennsylvania-specific compensation data supplied by the PA Bureau of Labor Statistics and considers the expected expenses for the delivery of the services under the waivers for the major allowable cost categories listed below:
  - -Wages for staff
  - -Employee-related expenses
  - -Productivity
  - -Program Indirect expenses
  - -Administration-related expenses
- OLTL develops geographical fees to reflect consideration for differences in wages observed across the Commonwealth.
- The fee schedule rates are established by the Department to fund the fee schedule services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.
- Rates for the following services are on the waiver fee schedule: Personal Assistance Services, Adult Daily Living Services (Basic and Enhanced), Community Integration, Home Health Services, Prevocational Services, Residential Habilitation, Residential Habilitation Enhanced staffing, Respite, Structured Day Habilitation, Supported Employment, Therapeutic and Counseling Services and Service Coordination.
- Additionally, OLTL reimburses the following services: Home Adaptations, Assistive Technology, Specialized Medical Equipment and Supplies, Vehicle Modifications, Non-Medical Transportation, Community Transition Services, and Personal Emergency Response System based on the cost charged to the general public for the good or service.
- Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.
- Once published in the Pennsylvania Bulletin, the rate notice and corresponding rates are available on the OLTL website for participants, providers and the general public's information. In addition, when the participant chooses to self-direct some or all of their services, the F/EA is responsible for informing the participant of the established

rate for that service.

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Providers are reimbursed retrospectively based on services provided.

Providers must submit claims through PROMISe, DHS's MMIS system. This system is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS).

In order to be paid for submitted claims, providers must be enrolled as Medical Assistance providers and entered as such into PROMISe.

PROMISe verifies participant information in the Client Information System (CIS), which contains MA participant's eligibility information, such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates.

PROMISe also verifies with HCSIS that the provider(s) and service(s) on the claim are included in the participant's approved waiver service plan.

Service Coordination providers that also serve as Organized Health Care Delivery Systems (OHCDS) providers (further outlined in Appendix I-3, g. ii. below) may serve as the fiscal intermediary for certain specified services. The OHCDS whether subcontracting or directly reimbursing the cost of the service provided by a provider or vender may not bill more than the actual cost of the service. The OHCDS will bill through PROMISe and all of the edits, systems checks, etc. as listed above will pertain.

Billing for recipients that choose to self-direct their services is more fully outlined in Appendix E. For Participant-Directed Personal Assistance Services, the F/EA will submit claims to PROMISe on behalf of the waiver participant employer. These claims will be billed through PROMISe, again going through all edit and system checks outlined above. The claims will only be submitted for appropriately approved direct care worker timesheets.

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

○	**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 (*check each that applies*):	
	☐	**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.*)
●	**No**. State or local government agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

OLTL ensures that the individual was eligible for Medicaid waiver payment on the date of service, the service was included in the participant's approved service plan, and the services were provided through the use of the following strategies and tools:

Billing validation is done first through PROMISe. PROMISe verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the OBRA Waiver.

After validation of the above listed items occurs, the claim information is sent to the Home and Community Services Information System (HCSIS) to be verified against the participants ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This fiscal accountability of services rendered provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. Resolutions of denied or suspended claims occur through error code notification.

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for

and the cost of services provided under the waiver. 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 HCSIS reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews. Finally, Service Coordinators are responsible for ensuring the proper information is entered into HCSIS correctly so providers can bill timely and accurately. Service Coordinators are responsible for monitoring the participant's ISP to ensure the participant is receiving the services as authorized in the ISP.

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-3: Payment

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) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

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.

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.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○	**Yes.** State or local government providers receive payment for waiver services. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
	One of the Financial Management Service providers is a county based Area Agency on Aging.
●	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. Amount of Payment to State or Local Government Providers. Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

●	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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 are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**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.
●	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

●	**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:
	a. Entities eligible for designation as OHCDS for services within this waiver are service coordination entities, all of which render at least one Medicaid service directly (Service Coordination) utilizing its own employees. b. Eligible entities may request enrollment. Such requests are reviewed and approved by OLTL prior to any service provided through the OHCDS arrangement. c. As described in Appendix D, individuals are fully informed of their right to choose from all willing and qualified providers and are not required to utilize the OHCDS arrangement. Providers who do not wish to affiliate with an OHCDS may always directly enroll as a provider with the Department. d. Through robust provider/SC oversight and monitoring, as well as through information garnered through service plan and claims data, OLTL monitors services provided through OHCDS to ensure that the OHCDS has contracted only with providers meeting established minimum qualifications. e. Through these oversight mechanisms, OLTL will also ensure that the arrangements meet State and Federal requirements f. The full amount of service dollars is passed through for the provision of service. g. The State assures financial accountability when an OHCDS arrangement is used by monitoring individual service plans and claims paid to the OHCDS entities through

	the comprehensive provider and SC monitoring processes performed by OLTL. The state ensures that the payment to the OHCDS does not result in excessive payments through the established process of paying only the cost of the service or good provided.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	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.
●	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

☑	**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:

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. *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:
☑	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

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 sources (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-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. (*Do not complete Item I-5-b*).
●	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

In accordance with 42 CFR 441.310(a)(2), the Commonwealth does not pay the cost of room and board. The fee schedule developed for all waiver services are based solely on service costs and does not include consideration for room and board. These payments are processed through the Commonwealth's MMIS system, PROMISe, and the cost of room and board is not included.

APPENDIX 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:

○	**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:*
●	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *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

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**

Level(s) of Care *(specify)*:							
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 (Column 7 less Column 4)**
1	$46505.94	$7661.00	$54166.94	$251,536.00	$10,038.00	$261,574.00	$207,407.06
2	$43546.27	$7814.00	$51360.27	$251,536.00	$10,239.00	$261,775.00	$210,414.73
3	$43240.18	$7970.00	$51210.18	$251,536.00	$10,444.00	$261,980.00	$210,769.82
4	$43240.18	$8130.00	$51370.18	$251,536.00	$10,653.00	$262,189.00	$210,818.82
5	$43237.65	$8292.00	$51529.65	$251,536.00	$10,866.00	$262,402.00	$210,872.35

Appendix J-2 - Derivation of Estimates

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:
Year 1	1694		1694
Year 2	1694		1694
Year 3	1694		1694
Year 4	1694		1694
Year 5	1694		1694

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-d.

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

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:

Factor D is obtained the same way as described under Factor D. The entire database of waiver participants is available to identify each participant's non-waiver MA costs, including the deduction of Medicare Part D drug costs. Payments made to institutions may not include all services that are available to participants through Medicaid. Factor D reflects a two percent (2%) increase each year. Factor G is based on actual claims history, which includes the deduction of Medicare drug costs. Factor G reflects a two percent (2%) increase each year. Both Factor D and Factor G are based upon historic utilization.

iii. **Factor G Derivation**. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on current ICF/ORC rates, and does not reflect any rate adjustments over the five year period.

iv. **Factor G′ Derivation**. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on actual claims history, which includes the deduction of Medicare drug costs. Factor G reflects a two percent (2%) increase each year.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

. **Estimate of Factor D – Non-Concurrent Waiver**. Complete the following table for each waiver year

	Waiver Year: Year 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Adult Day Living Total:						$368,562.55
Enhanced Full Day	Day	5	100.00	$71.74	$35,870	
Basic Full Day	Day	35	149.00	$59.73	$311,491.95	
Basic Half Day	Half Day	5	142.00	$26.86	$21,200.60	
Education Total						$336,751.80
Education	15 Min	33	370.00	$27.58	$336,751.80	
Personal Assistance Services Total:						$48,635,647.98
Personal Assistance	15 Min	719	6279.00	$4.58	$20,676,872.58	
Participant Directed	15 Min	1014	7747.00	$3.54	$27,808,321.32	
CSLA	15 Min	18	1756.00	$4.76	$150,454.08	
Prevocational Services Total:						$1,234,083.84
Prevocational Services	15 Min	66	2816.00	$6.64	$1,234,083.84	
Residential Habilitation Total:						$3,699,978.00
Licensed	Per Diem	33	300.00	$247.67	$2,451,933.00	
Unlicensed	Per Diem	15	300.00	$264.15	1188675.00	
Level 1	Hour	4	500.00	$19.79	39,580.00	
Level 2	Hour	1	500.00	$39.58	19,790.00	
Respite Total						$3,632,571.06
Agency	15 Min	213	1529.00	$4.58	$1,491,600.66	

	Waiver Year: Year 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Participant Directed	15 Min	360	1563.00	$3.54	$1,991,887.20	
Facility	Per Diem	70	12.00	$177.48	$149,083.20	
Service Coordination Totals:						$6,520,216.50
Service Coordination	Weekly	1635	45.00	$88.62	$6,520,216.50	
Structured Day Habilitation Services Total:						$2,339,815.00
Structured Day Habilitation Services	Hour	48	1375.00	$34.56	$2,280,960.00	
Level 1	Hour	4	500.00	$19.62	$39,240.00	
Level 2	Hour	1	500.00	$39.23	$19,615.00	
Supported Employment total:						$351,800.20
Supported Employment	Hour	38	215.00	$43.06	$351,800.20	
Home Health Total:						$3,260,790.22
Occupational Therapy	15 Min	34	192.00	$19.32	$126,120.96	
Speech Therapy	15 Min	34	217.00	$19.71	$145,420.38	
Physical Therapy	15 Min	34	244.00	$18.33	$152,065.68	
Nursing RN	15 Min	20	6074.00	$15.02	$1,824,629.60	
Nursing LPN	15 Min	15	6074.00	$10.00	$911,100.00	
Occupational Therapy Assistant	15 Min	20	192.00	$13.14	$50,457.60	
Physical Therapy Assistant	15 Min	20	244.00	$10.45	$50,966.00	
Financial Management Services Total:						$863,285.00
Financial Management Services	Month	1014	10.00	$85.00	$861,900.00	
Financial Management Services – Start up	One Time	5	1.00	$277.00	$1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						$1,293,628.00
Adaptation	Purchase	188	1.00	$5035.00	$946,580.00	
Equipment	Purchase	188	1.00	$1846.00	$347,048.00	
Community Integration Total:						$4,915,558.40
Community Integration	15 Min	380	1984.00	$6.52	$4,915,558.40	
Community Transition Services Total:						$20,000.00
Community Transition Services	Purchase	5	1.00	$4000.00	$20,000.00	

State:	
Effective Date	

	Waiver Year: Year 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Non-Medical Transportation Total:						$927,010.00
Non-Medical Transportation	Trip	779	119.00	$10.00	$927,010.00	
Personal Emergency Response System (PERS) Total:						$315,900.00
Personal Emergency Response System (PERS)	Month	702	10.00	$45.00	$315,900.00	
Therapeutic and Counseling Services Total:						$65,467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	$13.64	$17,240.96	
Counseling Services	15Min	9	147.00	$11.43	$15,121.89	
Nutritional Counseling	15 Min	8	147.00	$13.30	$15,640.80	
Behavior Therapy	15 Min	8	147.00	$14.85	$17,463.60	
GRAND TOTAL:						$78,781,065.80
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						1694
FACTOR D (Divide grand total by number of participants)						$46,505.94
AVERAGE LENGTH OF STAY ON THE WAIVER						300

State:	
Effective Date	

	Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Living Total:						$368,562.55
Enhanced Full Day	Day	5	100.00	$71.74	$35,870	
Basic Full Day	Day	35	149.00	$59.73	$311,491.95	
Basic Half Day	Half Day	5	142.00	$26.86	$21,200.60	
Education Total						$0.00
Education	15 Min	0	370.00	$27.58	$336,751.80	
Personal Assistance Services Total:						$48,635,6647.98
Personal Assistance	15 Min	719	6279.00	$4.58	$20,676,872.58	
Participant Directed	15 Min	1014	7747.00	$3.54	$27,808,321.32	
CSLA	15 Min	18	1756.00	$4.76	$150,454.08	
Prevocational Services Total:						$1,234,083.84
Prevocational Services	15 Min	66	2816.00	$6.64	$1,234,083.84	
Residential Habilitation Total:						$3,699,978.00
Licensed	Per Diem	33	300.00	$247.67	$2,451,933.00	
Unlicensed	Per Diem	15	300.00	$264.15	1188675.00	
Level 1	Hour	4	500.00	$19.79	39,580.00	
Level 2	Hour	1	500.00	$39.58	19,790.00	
Respite Total						$3,483,487.86
Agency	15 Min	213	1529.00	$4.58	$1,491,600.66	
Participant Directed	15 Min	360	1563.00	$3.54	$1,991,887.20	
Facility	Per Diem	0	12.00	$177.48	$149,083.20	
Service Coordination Totals:						$2,337,134.40
Service Coordination	15 Min	1635	96.00	$14.89	$2,337,134.40	
Structured Day Habilitation Services Total:						$2,339,815.00
Structured Day Habilitation Services	Hour	48	1375.00	$34.56	$2,280,960.00	
Level 1	Hour	4	500.00	$19.62	$39,240.00	
Level 2	Hour	1	500.00	$39.23	$19,615.00	
Supported Employment total:						$351,800.20
Supported Employment	Hour	38	215.00	$43.06	$351,800.20	
Home Health Total:						$3,260,790.22
Occupational Therapy	15 Min	34	192.00	$19.32	$126,120.96	
Speech Therapy	15 Min	34	217.00	$19.71	$145,420.38	

State:	
Effective Date	

	Waiver Year: Year 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Physical Therapy	15 Min	34	244.00	$18.33	$152,065.68	
Nursing RN	15 Min	20	6074.00	$15.02	$1,824,629.60	
Nursing LPN	15 Min	15	6074.00	$10.00	$911,100.00	
Occupational Therapy Assistant	15 Min	20	192.00	$13.14	$50,457.60	
Physical Therapy Assistant	15 Min	20	244.00	$10.45	$50,966.00	
Financial Management Services Total:						$518,525.00
Financial Management Services	Month	1014	6.00	$85.00	$517,140.00	
Financial Management Services – Start up	One Time	5	1.00	$277.00	$1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						$1,293,628.00
Adaptation	Purchase	188	1.00	$5035.00	$946,580.00	
Equipment	Purchase	188	1.00	$1846.00	$347,048.00	
Community Integration Total:						$4,915,558.40
Community Integration	15 Min	380	1984.00	$6.52	$4,915,558.40	
Community Transition Services Total:						$20,000.00
Community Transition Services	Purchase	5	1.00	$4000.00	$20,000.00	
Non-Medical Transportation Total:						$927,010.00
Non-Medical Transportation	Trip	779	119.00	$10.00	$927,010.00	
Personal Emergency Response System (PERS) Total:						$315,900.00
Personal Emergency Response System (PERS)	Month	702	10.00	$45.00	$315,900.00	
Therapeutic and Counseling Services Total:						$65,467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	$13.64	$17,240.96	
Counseling Services	15Min	9	147.00	$11.43	$15,121.89	
Nutritional Counseling	15 Min	8	147.00	$13.30	$15,640.80	
Behavior Therapy	15 Min	8	147.00	$14.85	$17,463.60	
GRAND TOTAL:						$73,767,388.70

State:	
Effective Date	

	Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						1694
FACTOR D (Divide grand total by number of participants)						$43,546.27
AVERAGE LENGTH OF STAY ON THE WAIVER						300

	Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Living Total:						$368,562.55
Enhanced Full Day	Day	5	100.00	$71.74	$35,870	
Basic Full Day	Day	35	149.00	$59.73	$311,491.95	
Basic Half Day	Half Day	5	142.00	$26.86	$21,200.60	
Education Total						$0.00
Education	15 Min	0	370.00	$27.58	$336,751.80	
Personal Assistance Services Total:						$48,635,647.98
Personal Assistance	15 Min	719	6279.00	$4.58	$20,676,872.58	
Participant Directed	15 Min	1014	7747.00	$3.54	$27,808,321.32	
CSLA	15 Min	18	1756.00	$4.76	$150,454.08	
Prevocational Services Total:						$1,234,083.84
Prevocational Services	15 Min	66	2816.00	$6.64	$1,234,083.84	
Residential Habilitation Total:						$3,699,978.00
Licensed	Per Diem	33	300.00	$247.67	$2,451,933.00	
Unlicensed	Per Diem	15	300.00	$264.15	1188675.00	
Level 1	Hour	4	500.00	$19.79	39,580.00	
Level 2	Hour	1	500.00	$39.58	19,790.00	
Respite Total						$3,483,487.86
Agency	15 Min	213	1529.00	$4.58	$1,491,600.66	
Participant Directed	15 Min	360	1563.00	$3.54	$1,991,887.20	
Facility	Per Diem	0	12.00	$177.48	$149,083.20	
Service Coordination Totals:						$2,337,134.40
Service Coordination	15 Min	1635	96.00	$14.89	$2,337,134.40	
Structured Day Habilitation Services Total:						$2,339,815.00
Structured Day Habilitation Services	Hour	48	1375.00	$34.56	$2,280,960.00	
Level 1	Hour	4	500.00	$19.62	$39,240.00	
Level 2	Hour	1	500.00	$39.23	$19,615.00	
Supported Employment total:						$351,800.20
Supported Employment	Hour	38	215.00	$43.06	$351,800.20	
Home Health Total:						$3,260,790.22
Occupational Therapy	15 Min	34	192.00	$19.32	$126,120.96	
Speech Therapy	15 Min	34	217.00	$19.71	$145,420.38	

State:	
Effective Date	

	Waiver Year: Year 3					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Physical Therapy	15 Min	34	244.00	$18.33	$152,065.68	
Nursing RN	15 Min	20	6074.00	$15.02	$1,824,629.60	
Nursing LPN	15 Min	15	6074.00	$10.00	$911,100.00	
Occupational Therapy Assistant	15 Min	20	192.00	$13.14	$50,457.60	
Physical Therapy Assistant	15 Min	20	244.00	$10.45	$50,966.00	
Financial Management Services Total:						$0.00
Financial Management Services	Month	0	10.00	$85.00	$861,900.00	
Financial Management Services – Start up	One Time	0	1.00	$277.00	$1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						$1,293,628.00
Adaptation	Purchase	188	1.00	$5035.00	$946,580.00	
Equipment	Purchase	188	1.00	$1846.00	$347,048.00	
Community Integration Total:						$4,915,558.40
Community Integration	15 Min	380	1984.00	$6.52	$4,915,558.40	
Community Transition Services Total:						$20,000.00
Community Transition Services	Purchase	5	1.00	$4000.00	$20,000.00	
Non-Medical Transportation Total:						$927,010.00
Non-Medical Transportation	Trip	779	119.00	$10.00	$927,010.00	
Personal Emergency Response System (PERS) Total:						$315,900.00
Personal Emergency Response System (PERS)	Month	702	10.00	$45.00	$315,900.00	
Therapeutic and Counseling Services Total:						$65,467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	$13.64	$17,240.96	
Counseling Services	15Min	9	147.00	$11.43	$15,121.89	
Nutritional Counseling	15 Min	8	147.00	$13.30	$15,640.80	
Behavior Therapy	15 Min	8	147.00	$14.85	$17,463.60	
GRAND TOTAL:						$73,248,863.70

State:	
Effective Date	

	Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						1694
FACTOR D (Divide grand total by number of participants)						$43,240.18
AVERAGE LENGTH OF STAY ON THE WAIVER						300

	Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Living Total:						$368,562.55
Enhanced Full Day	Day	5	100.00	$71.74	$35,870	
Basic Full Day	Day	35	149.00	$59.73	$311,491.95	
Basic Half Day	Half Day	5	142.00	$26.86	$21,200.60	
Education Total						$0.00
Education	15 Min	0	370.00	$27.58	$336,751.80	
Personal Assistance Services Total:						$48,635,647.98
Personal Assistance	15 Min	719	6279.00	$4.58	$20,676,872.58	
Participant Directed	15 Min	1014	7747.00	$3.54	$27,808,321.32	
CSLA	15 Min	18	1756.00	$4.76	$150,454.08	
Prevocational Services Total:						$1,234,083.84
Prevocational Services	15 Min	66	2816.00	$6.64	$1,234,083.84	
Residential Habilitation Total:						$3,699,978.00
Licensed	Per Diem	33	300.00	$247.67	$2,451,933.00	
Unlicensed	Per Diem	15	300.00	$264.15	1188675.00	
Level 1	Hour	4	500.00	$19.79	39,580.00	
Level 2	Hour	1	500.00	$39.58	19,790.00	
Respite Total						$3,483,487.86
Agency	15 Min	213	1529.00	$4.58	$1,491,600.66	
Participant Directed	15 Min	360	1563.00	$3.54	$1,991,887.20	
Facility	Per Diem	0	12.00	$177.48	$149,083.20	
Service Coordination Totals:						$2,337,134.40
Service Coordination	15 Min	1635	96.00	$14.89	$2,337,134.40	
Structured Day Habilitation Services Total:						$2,339,815.00
Structured Day Habilitation Services	Hour	48	1375.00	$34.56	$2,280,960.00	
Level 1	Hour	4	500.00	$19.62	$39,240.00	
Level 2	Hour	1	500.00	$39.23	$19,615.00	
Supported Employment total:						$351,800.20
Supported Employment	Hour	38	215.00	$43.06	$351,800.20	
Home Health Total:						$3,260,790.22
Occupational Therapy	15 Min	34	192.00	$19.32	$126,120.96	
Speech Therapy	15 Min	34	217.00	$19.71	$145,420.38	

State:	
Effective Date	

	Waiver Year: Year 4					
	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
Physical Therapy	15 Min	34	244.00	$18.33	$152,065.68	
Nursing RN	15 Min	20	6074.00	$15.02	$1,824,629.60	
Nursing LPN	15 Min	15	6074.00	$10.00	$911,100.00	
Occupational Therapy Assistant	15 Min	20	192.00	$13.14	$50,457.60	
Physical Therapy Assistant	15 Min	20	244.00	$10.45	$50,966.00	
Financial Management Services Total:						$0.00
Financial Management Services	Month	0	10.00	$85.00	$861,900.00	
Financial Management Services – Start up	One Time	0	1.00	$277.00	$1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						$1,293,628.00
Adaptation	Purchase	188	1.00	$5035.00	$946,580.00	
Equipment	Purchase	188	1.00	$1846.00	$347,048.00	
Community Integration Total:						$4,915,558.40
Community Integration	15 Min	380	1984.00	$6.52	$4,915,558.40	
Community Transition Services Total:						$20,000.00
Community Transition Services	Purchase	5	1.00	$4000.00	$20,000.00	
Non-Medical Transportation Total:						$927,010.00
Non-Medical Transportation	Trip	779	119.00	$10.00	$927,010.00	
Personal Emergency Response System (PERS) Total:						$315,900.00
Personal Emergency Response System (PERS)	Month	702	10.00	$45.00	$315,900.00	
Therapeutic and Counseling Services Total:						$65,467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	$13.64	$17,240.96	
Counseling Services	15Min	9	147.00	$11.43	$15,121.89	
Nutritional Counseling	15 Min	8	147.00	$13.30	$15,640.80	
Behavior Therapy	15 Min	8	147.00	$14.85	$17,463.60	
GRAND TOTAL:						$73,248,863.70

State:	
Effective Date	

	Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Component Cost**	**Total Cost**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						1694
FACTOR D (Divide grand total by number of participants)						$43,240.18
AVERAGE LENGTH OF STAY ON THE WAIVER						300

	Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Living Total:						$368,562.55
Enhanced Full Day	Day	5	100.00	$71.74	$35,870	
Enhanced – Half Day	Half-Day				To Be Determined	
Basic Full Day	Day	35	149.00	$59.73	$311,491.95	
Basic Half Day	Half Day	5	142.00	$26.86	$21,200.60	
Education Total						$0.00
Education	15 Min	0	370.00	$27.58	$336,751.80	
Personal Assistance Services Total:						$48,635,647.98
Personal Assistance	15 Min	719	6279.00	$4.58	$20,676,872.58	
Participant Directed	15 Min	1014	7747.00	$3.54	$27,808,321.32	
CSLA	15 Min	18	1756.00	$4.76	$150,454.08	
Prevocational Services Total:						$1,234,083.84
Prevocational Services	15 Min	66	2816.00	$6.64	$1,234,083.84	
Residential Habilitation Total:						$3,699,978.00
Licensed	Per Diem	33	300.00	$247.67	$2,451,933.00	
Unlicensed	Per Diem	15	300.00	$264.15	1188675.00	
Level 1	Hour	4	500.00	$19.79	39,580.00	
Level 2	Hour	1	500.00	$39.58	19,790.00	
Respite Total						$3,483,487.86
Agency	15 Min	213	1529.00	$4.58	$1,491,600.66	
Participant Directed	15 Min	360	1563.00	$3.54	$1,991,887.20	
Facility	Per Diem	0	12.00	$177.48	$149,083.20	
Service Coordination Totals:						$2,332,846.08
Service Coordination	15 Min	1635	96.00	$14.89	$2,332,846.08	
Structured Day Habilitation Services Total:						$2,339,815.00
Structured Day Habilitation Services	Hour	48	1375.00	$34.56	$2,280,960.00	
Level 1	Hour	4	500.00	$19.62	$39,240.00	
Level 2	Hour	1	500.00	$39.23	$19,615.00	
Supported Employment total:						$351,800.20
Supported Employment	Hour	38	215.00	$43.06	$351,800.20	
Home Health Total:						$3,260,790.22
Occupational Therapy	15 Min	34	192.00	$19.32	$126,120.96	

	Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy	15 Min	34	217.00	$19.71	$145,420.38	
Physical Therapy	15 Min	34	244.00	$18.33	$152,065.68	
Nursing RN	15 Min	20	6074.00	$15.02	$1,824,629.60	
Nursing LPN	15 Min	15	6074.00	$10.00	$911,100.00	
Occupational Therapy Assistant	15 Min	20	192.00	$13.14	$50,457.60	
Physical Therapy Assistant	15 Min	20	244.00	$10.45	$50,966.00	
Financial Management Services Total:						$0.00
Financial Management Services	Month	0	10.00	$85.00	$861,900.00	
Financial Management Services – Start up	One Time	0	1.00	$277.00	$1385.00	
						$1,293,628.00
Home Adaptations	Purchase				To Be Determined	
Vehicle Modifications	Purchase				To Be Determined	
Assistive Technology	Purchase				To Be Determined	
Specialized Medical Equipment and Supplies	Purchase				To Be Determined	
Community Integration Total:						$4,915,558.40
Community Integration	15 Min	380	1984.00	$6.52	$4,915,558.40	
Community Transition Services Total:						$20,000.00
Community Transition Services	Purchase	5	1.00	$4000.00	$20,000.00	
Non-Medical Transportation Total:						$927,010.00
Non-Medical Transportation	Trip	779	119.00	$10.00	$927,010.00	
Personal Emergency Response System (PERS) Total:						$315,900.00
Personal Emergency Response System (PERS)	Month	702	10.00	$45.00	$315,900.00	
Therapeutic and Counseling Services Total:						$65,467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	$13.64	$17,240.96	

State:	
Effective Date	

	Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col 5	Col. 6
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling Services	15Min	9	147.00	$11.43	$15,121.89	
Nutritional Counseling	15 Min	8	147.00	$13.30	$15,640.80	
Behavior Therapy	15 Min	8	147.00	$14.85	$17,463.60	
GRAND TOTAL:						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						1694
FACTOR D (Divide grand total by number of participants)						
AVERAGE LENGTH OF STAY ON THE WAIVER						300

State:	
Effective Date	