COMMCARE and Independence Waiver Renewals
Aging, Attendant Care and OBRA Waiver Amendments
Side-by-Side Comparison of Current and Revised Language

Appendix and Waiver Section	Current Language	Revised Language	Waiver Affected	Commenter Name, Date Submitted and Comment
Appendix A: Waiver Administration and Operation				
Appendix A-2-a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency	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 [COMMCARE, Independence, OBRA] Waiver. The Deputy Secretary of the Office of Long Term Living reports directly to the Secretaries of Aging and Public Welfare. The Secretary of Public Welfare is the head of the single state Medicaid agency. The Office of Long Term Living functions as part of both of the Departments of Aging and Public Welfare. The Secretary of Public Welfare, the State Medicaid Director and the Deputy Secretary of Long Term Living meet weekly to discuss operations of the waivers and other long term living programs. Therefore, the SMA through Secretary of Public Welfare has ultimate authority over operations of the waiver	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 [COMMCARE, Independence, 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 State Medicaid Director (Deputy Secretary of the Office of Medical Assistance Programs (OMAP)) and the Deputy Secretary of the Office of Long-Term Living meet weekly to discuss operations of the waivers and other long term living programs. In addition, OLTL and OMAP policy staff meets regularly to review and gain consent on Waiver policies, rules and guidelines. Descriptions of the functions of the operating	COMMCARE, Independence, OBRA	

		divisions within the Department, including OLTL and OMAP, 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.		
Appendix A-3: Use of Contracted Entities	The Office of Long-Term Living contracts with the Area Agencies on Aging to perform Level of Care Assessments. In addition, effective July 1, 2010, the Office of Long-Term Living will be contracting with a non-governmental non-state entity to perform enrollment activities for the [COMMCARE, Independence, OBRA] waiver.	OLTL retains the authority over the administration of the [COMMCARE, Independence, 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 [COMMCARE, Independence and OBRA] waiver. Specifically, the Independent Enrollment Broker (IEB) is responsible for the	COMMCARE, Independence, OBRA	

		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 Nursing Facility institutional services, waiver services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form; • Provide applicants with 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; • Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); 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 (Budget Authority only). In addition to these delegated activities, the FMS 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 Office of Medical Assistance Programs (OMAP). The assessment methods used to monitor performance		

		of contracted entities are described below in A-1-6 below.		
Appendix A-4: Role of Local/Regional Non-State Public Entities	OLTL retains the authority for all administrative decisions and supervision of non-state public agencies that conduct waiver operational and administrative functions. A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 35 of the AAAs are non-state public agencies. A physician certifies level of care and the AAA completes the Level of Care Assessment (LOCA) form. The LOCA is designed to determine whether an individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI).	As noted above, OLTL retains the authority over the administration of the [COMMCARE, Independence and 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 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.	COMMCARE, Independence and OBRA	
Appendix A-4: Role of Local/Regional Non-Governmental Non-State Entities	OLTL retains the authority for all administrative decisions and supervision of non-governmental non-state agencies that conduct waiver operational and administrative functions. Enrollment - OLTL has state level oversight authority over the enrollment function. OLTL currently has agreements with enrolling agencies covering all 67 counties. Currently, 17	OLTL retains the authority over the administration of the [COMMCARE, Independence and 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	COMMCARE, Independence and OBRA	

	local enrolling agencies perform participant intake and enrollment functions. Local enrolling agencies consist of non-governmental non-state entities such as Centers for Independent Living, local United Cerebral Palsy offices, or local human services offices. The SMA recognizes that having the same local agency process a participant's waiver enrollment and also provide services to the same participant creates a conflict of interest. OLTL has issued a Request for Proposal (RFP) for one independent entity to perform enrollment activities for all waivers managed by OLTL, with the exception of the Aging waiver. Effective July 1, 2010, the independent enrolling agency will handle waiver enrollments and will not provide any ongoing services to the participant. A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 17 of the AAAs are non-state public agencies. A physician certifies level of care and the AAA completes the Level of Care Assessment (LOCA) form. The LOCA is designed to determine whether an individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI).	non-state agencies that conduct Waiver operational and administrative functions. Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates 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.		
Appendix A-5: Responsibility for	Office of Long Term Living, Bureau of Individual Supports and Office of Quality Management,	OLTL remains the ultimate authority for Waiver policies, rules, and regulations; and retains the	COMMCARE, Independence and	

Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.	Metrics and Analytics.	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 OLTL sponsored training, targeted technical assistance, and upon request.	OBRA	
Appendix A-6: Assessment Methods and Frequency	The Office of Long-Term Living (OLTL) oversees the performance of the enrollment function delegated to the Independent Enrollment Broker. OLTL oversees the performance of the initial assessment functions that are delegated to the local Area Agencies on Aging (AAAs). OLTL oversees the performance of the annual reevaluation function delegated to Service Coordination Agencies. OLTL generates quarterly benchmark reports that measure timeliness of enrollment, level of care determinations, service utilization and other activities performed by contracted and Local/Regional Non-State Entities. Quality Management Efficiency Teams (QMET) conduct bi-annual reviews of all providers. The QMETs review monitor providers performance and adherence to the waiver standards. Ongoing monitoring of requirements for waiver	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	COMMCARE, Independence and OBRA	

	eligibility, budgeting, provider enrollment and service delivery are completed electronically through the Home and Community Services Information System (HCSIS), and the Provider Reimbursement Operations Management Information System (PROMISe).	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.		
Appendix A-7: Distribution of Waiver Operational and Administrative Functions	The chart notes that participant enrollment and level of care evaluations, as described above, are functions delegated to AAAs.	Chart within renewal application identifies all functions delegated to AAAs, IEB and FMS entity as described above.	COMMCARE, Independence and OBRA	
Appendix B:				
Appendix B-1: Specification of the Target Group	Must be age 21 and over with a traumatic brain injury.	Must be age 21 and over with a medically determinable diagnosis of traumatic brain injury. TBI is defined as a sudden insult or damage by an external physical force to the brain or its coverings, not of a degenerative, congenital or post-operative nature, which is expected to last indefinitely and results in substantial functional limitations in three or more of the following life activities: mobility, behavior, communication, self-care, self- direction, independent living, cognitive capacity (judgment, memory and reasoning."	COMMCARE	
Appendix B-3-f: Selection of Entrants 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. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance	All individuals that are eligible for the waiver will be served. In the event that a waiting list for waiver services becomes necessary, individuals removed from the waiting list will be determined based upon date of application for services and according to the following order of priority:	COMMCARE and Independence	

	in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community. 2. Individuals who are at risk of nursing home placement. Individuals who currently reside in the community and are at imminent risk of nursing 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.	1. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community. OR Individuals who are at imminent risk of nursing home placement. Individuals who currently reside in the community and are at imminent risk of nursing facility placement within 24-72 hours or less. 2. Individuals who are in the community but can wait more than 72 hours for home and community-based services.		
Appendix B-6-a: Reasonable Indication of Need for Services	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is 1	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is 2.	COMMCARE and Independence	
Appendix B-6-b: Responsibility for Performing Evaluations and Reevaluations	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. The Service Coordinators conduct the annual reevaluations for participants that are already enrolled in the waiver. Service Coordinators also conduct reevaluations more frequently, if needed.	The local Area Agencies on Aging (AAA) Assessors conduct the initial level of care determinations for individuals referred for waiver services. In addition a physician (M.D or D.O) completes the physician certification form which indicates the physician's diagnosis and a level of care recommendation. The [COMMCARE or Independence] Waiver Service Coordinators conduct the annual reevaluations for participants that are already enrolled in the waiver. In addition, Service Coordinators are required to conduct reevaluations more frequently, if needed, when there are changes in a participant's functioning and/or needs.	COMMCARE and Independence	
Appendix B-6-b: Qualifications of	AAA Assessors One year experience in public or private social	AAA Assessors must meet the following qualifications:	COMMCARE and Independence	

Individuals Performing Initial Evaluations	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	1. 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 2. 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 3. One year assessment experience and a bachelor's degree with social welfare major OR 4. 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		

	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 Licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code.	be substituted for one year assessment experience. The equivalency statement in the items noted above 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. Physicians must be licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code. Individuals conducting redeterminations (Service Coordinators) must meet the provider qualifications as outlined below and in Appendix C.		
Appendix B-6-d: Level of Care Criteria	Under Federal and State law and regulations, which identify the level of care provided in a nursing facility, a consumer should be considered NFCE if: 1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; and 2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board; and 3. A physician certifies that the individual is NFCE; and 4. The care and services are either a) skilled nursing or rehabilitation services	An individual is NFCE if he or she needs the level of care provided in a nursing facility. Under Federal and State law and regulations, which identify the level of care provided in a nursing facility, a consumer should be considered NFCE if: 1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; and 2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board; and 3. A physician certifies that the individual is NFCE; and	COMMCARE and Independence	

	as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities. The Level of Care Determination is made using the Level of Care Assessment tool (LOCA) and a prescription.	4. The care and services are either a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities. The Level of Care Determination is made using a standardized level of care evaluation tool and physician certification form which indicates the physician's diagnosis and level of care recommendation.		
Appendix B-6-e: Level of Instrument	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.	The same instrument is used for institutional and initial waiver level of care. A different instrument is used for reevaluations. Service Coordinators utilize the standardized needs assessment tool to conduct the annual reevaluation of level of care. The needs assessment tool is the comprehensive assessment tool utilized by all OLTL home and community-based service programs to collect information about the participant's strengths, capacities, needs, preferences, health status, risk factors and desired goals, which is used to develop the participant's Individual Service Plan (ISP). A Section of the needs assessment mirrors the information collected in the standardized level of care evaluation tool, including information on medical changes, recent hospitalizations and changes in functional status	COMMCARE and Independence	

		(ADLs and IADLs). The information collected on the needs assessment is compared to the information collected in the individual's previous evaluation or reevaluation which assists the Service Coordinator to identify changes and make the level of care reevaluation eligibility determination. Through a retrospective review of a valid statistical sample of service plans, OLTL monitors that the needs assessment is yielding results comparable to the initial level of care assessment conducted by the local AAA.		
Appendix B-6-f: Process for Level of Care Evaluation/ Reevaluation	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 COMMCARE Waiver services through the Independent enrolling agency. The role of the independent enrollment agency is to facilitate and support the participant through the enrollment process including the level of care evaluation. The enrolling agency 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 enrolling agency assists the participant with obtaining a completed prescription from the participant's physician (M.D. or D.O.) • A physician completes a prescription form	Initial Level of Care Evaluation – OLTL uses the following process to determine an individual's initial level of care: • The participant first applies for [COMMCARE, Independence] Waiver services through the statewide Independent Enrolling Agency. • The IEB assists the participant with obtaining a completed physician certification form from the participant's physician (M.D. or D.O.) • The physician completes the physician certification form indicating the participant's diagnosis and the physician's level of care recommendation. • The IEB forwards the physician's certification form along with a request for a level of care assessment to the local (AAA). • The AAA assessor visits the participant and uses the standardized level of care evaluation to identify information regarding the participant's medical status, recent hospitalization, and functional ability (ADLs and IADLs). The same level of care is used in all 67 counties for all	COMMCARE and Independence	

	indicating the physician's level of care recommendation. • The enrolling agency 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 hospitalization, and functional ability (ADLs and IADLs). • 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, and changes in functional status (ADLs and IADLs). • The information collected on the Reassessment form is compared to the information collected in the individual's	individuals entering the waiver, and is the same tool used to determine institutional level of care. • The IEB 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 AAA is responsible for making the final level of care evaluation decision subject to OLTL oversight. 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 the standardized needs assessment form. • The standardized needs assessment form mirrors the information collected in the level of care evaluation tool, including information on medical changes, recent hospitalizations, and changes in functional status (ADLs and IADLs). • The information collected on the needs assessment form is compared to the information collected in the individual's previous evaluation or reevaluation. • The Service Coordination Entity is responsible for making the final level of care reevaluation determinations, subject to OLTL oversight.		

	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.	OLTL ensures that the annual reevaluation process is completed on time and consistent with OLTL policies through the following methods: 1. A retrospective review of valid statistical sample of service plans as described in the Quality Improvement section of Appendix D. When issues are identified, OLTL follows up with the identified Service Coordination Entity and provides targeted technical assistance. 2. On-site monitoring of Service Coordination Entities. The QMET reviews participant records to ensure the annual reevaluation was completed within 365 days from the initial level of care determination and ensure accuracy. OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations referenced in the Quality Improvement section below.		
Appendix B-6-h: Qualifications of Individuals Who Perform Reevaluations	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	Individuals performing reevaluations are [COMMCARE, Independence] waiver service coordinators. These individuals must meet the following qualifications: 1. Have a bachelor's degree including or supplemented by at least 12 college-level credit hours in sociology, social welfare, psychology, gerontology or another behavioral science. 2. A combination of experience and training which adds up to four years of experience, and education which includes at least 12 semester hours of college-level courses in sociology, social work, social welfare, psychology, gerontology or other social science.	COMMCARE and Independence	

	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 Coordinators working with individuals with traumatic brain injury must also have at least one year of experience in rehabilitation and/or working with individuals with traumatic brain injury Service Coordinator Supervisor must meet the same qualifications as the Service Coordinator including two years experience as a Service Coordinator	• Experience includes: coordinating assigned services as part of an individual's treatment plan; teaching individuals living skills; aiding in therapeutic activities; and providing socialization opportunities for individuals. • Experience does not include: Providing hands-on personal care for people with disabilities or individual over the age of 60; maintenance of an individual's home, room or environment; and aiding in adapting the physical facilities of an individual's home. Service Coordination Supervisors must meet one of the following: 1. Have at least three years experience in public or private social work and a bachelor's degree. 2. Have a combination of experience and education equaling at least three years of experience in public or private social work including at least 12 college-level credit hours in sociology, social work, psychology, gerontology or other related social science. Graduate coursework in the behavioral sciences may be substituted for up to two years of the required experience. Behavioral sciences include, but are not limited to, anthropology, counseling, criminology, gerontology, human behavior, psychology, social work, social welfare, sociology and special education. OLTL has developed training curriculum and provides periodic regional training to Service Coordinators through the initial OLTL Service Coordination training and the Individual Service		

		Plan (ISP) training. This curriculum provides specific instruction on the execution of the reevaluation for level of care, among other competency areas. In addition, Service Coordinators must meet the training requirements as outlined in 55 PA Code Chapter 52.27. During the on-site biennial provider monitoring visits, the QMET reviews employee personnel files to ensure individuals performing reevaluations meet the qualifications outlined in 55 PA Code Chapter 52 and above.		
Appendix B-6-i: Procedures to Ensure Timely Reevaluations	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.	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 standardized needs assessment. In addition, each Service Coordination agency maintains its own tickler system to complete timely reevaluations and maintain consistency in service. Service Coordinators are required to conduct reevaluations more frequently, if needed, when there are changes in a participant's functioning and/or needs. 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 biennial monitoring visits and retrospective service plan review process as described in the Quality Improvement section of Appendix D.	COMMCARE and Independence	
Appendix B-6-j: Maintenance of	Home and Community Services Information System (HCSIS)	Documentation of the participant's initial level of care determination is electronically maintained in	COMMCARE and Independence	

Evaluation/ Reevaluation Records	Service Coordinators maintain copies of evaluations in participant's record located at the Service Coordination agency	SAMS. In addition, Service Coordinators maintain copies of evaluations and reevaluation in participant's file located at the Service Coordination Entity		
Appendix B-7: Freedom of Choice	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 [COMMCARE or Independence] Waiver services and the participant is determined to likely meet the Nursing Facility Clinically Eligible (NFCE) level of care, the individual will be: • •Informed by the enrolling agency of any feasible service delivery alternatives available under the waiver; and, • •Given the choice of receiving NF institutional 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 enrolling agency and ongoing by their Service	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 [COMMCARE, Independence] Waiver services and the participant is determined to likely require Nursing Facility level of care, the individual will be: • Informed by the IEB of all available home and community-based service delivery alternatives, including the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over; and, • Given the choice of receiving Nursing Facility institutional services, waiver services, LIFE program services as appropriate, 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 IEB and ongoing by their Service Coordinator, of their right to choose	COMMCARE and Independence	

	Coordinator, of their right to choose between receiving home and community-based waiver services, Nursing Facility services, remaining 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 enrolling agency is responsible for ensuring that 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. In addition, the enrolling agency 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 enrolling agency 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 provider. 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	between receiving community services in the waiver, NF services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form during the initial enrollment process and at time of the annual reevaluation. Documentation is made in the participant's file that the form was completed; completed forms are maintained in the participant's file. Participant Freedom of Choice of Providers The IEB 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 IEB is responsible for educating participants of their right to choose from any qualified provider, their right to self-direct some or all of their direct services, and that they have the right to change providers at any time. The IEB will give each participant information about the Services and Supports Directory - a web-based listing of all qualified and enrolled waiver providers. 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. Notation is made in the participant's record of receipt of the OLTL Service Provider Choice Form; completed forms are maintained in the participant's file with the Service Coordination Entity. OLTL monitors participant receipt of forms as part of its		

	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. Service Coordination agencies are prohibited from providing direct services to those individuals for whom they are providing service coordination. 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 provider. OLTL monitors participant receipt of the forms as part of its bi-annual provider reviews.	biennial review of providers. The Service Coordination Entity is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial Individual Service Plan, 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, completed 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 Entity. OLTL monitors participant receipt of the forms as part of its biennial provider reviews.		
Appendix B-7: Access to Services by Limited English Proficient Persons	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. Each provider is required to have and implement policies and procedures for ensuring language assistance service to people who have limited proficiency in English.	Providers will make waiver documents available in different languages upon request, at no charge. Language assistance will be provided by the provider without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing. All providers are required to have and implement policies and procedures for participants with limited English proficiency to ensure meaningful access to language services as required by 55 Pa. Code Chapter 52.	COMMCARE and Independence	
Appendix C: Participant Services				
C-2-a: Criminal History	Effective July 1, 2008, criminal history	Criminal history checks are required for all support service workers and must be conducted in	COMMCARE,	

and/or Background Investigations	background checks are required for all individuals performing personal assistance services. Individuals choosing to self-direct their services have the right to employ a worker regardless of the outcome of the background check. Participants using the Consumer Employer model of service may choose to have a criminal background check completed on individuals who were hired before the date of July 1, 2008. 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 The F/EA is responsible for securing criminal history background checks for prospective support 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) the individual's decision to employ a support worker with a criminal record and their acceptance of responsibility for their decision. 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	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	Independence and OBRA	

	Pennsylvania State Police access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC) for this information. In the interim of securing the written results of the criminal history, the agency will obtain a written certification from the employee which confirms that either the employee has never been convicted of a felony or discloses prior convictions. The employee attests to understanding that if the certification is contradicted by the criminal clearance results, the employee may face immediate dismissal from employment in the waiver program. The decision to dismiss an employee based on criminal background check results rests solely with the employer of record. OLTL reviews provider personnel records as part of the annual monitoring to ensure that criminal history checks are documented.	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.		
C-2-b: Abuse Registry Screening	Written results of child abuse clearances are required for all direct care workers providing services in homes where children reside. These clearances are obtained from the Office of Children, Youth and Families, DPW-Childline and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717)783-6211 within 30 work days from the date the employee/provider initiates services to the participant. In the interim of securing the written results of	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,	COMMCARE, Independence and OBRA	

	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 enrollment into the waiver program been named on a central child abuse registry as being 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. The F/EA is responsible for securing child abuse clearances for prospective support 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.	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 enrollment into 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.		
C-2-e: Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians	Personal Assistance Services workers may be members of the participant's family, excluding the following: • The COMMCARE Waiver will not pay for services furnished to a minor by the child's parent or step-parent, or by the participant's spouse. • The COMMCARE Waiver will not pay for services furnished by a legal guardian. • The COMMCARE Waiver will not pay for services furnished by a Representative Payee. This requirement may be waived under special circumstances, if reviewed and approved by OLTL. • The COMMCARE Waiver will not pay for services furnished by a Power of Attorney (POA). This requirement may be waived under special circumstances, if reviewed and approved by OLTL. Family members who provide Personal Assistance Services must meet the same provider qualification standards as Personal Assistance Services workers who provide	Family members can provide Personal Assistance Services; however, the following exclusions apply: • The [Aging, Attendant Care, COMMCARE, Independence, OBRA] Waiver will not pay for services furnished by the participant's spouse. • The [Aging, Attendant Care, COMMCARE, Independence, OBRA] Waiver will not pay for services furnished by a legal guardian. • The [Aging, Attendant Care, COMMCARE, Independence, OBRA] Waiver will not pay for services furnished by a Representative Payee. This requirement may be waived under special circumstances, if reviewed and approved by OLTL. • The [Aging, Attendant Care, COMMCARE, Independence, OBRA] Waiver will not pay for services furnished by a Power of Attorney (POA). This requirement may be waived under special circumstances, if reviewed and approved by OLTL. 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-	Aging, Attendant Care, COMMCARE, Independence and OBRA	

	Personal Assistance Services to non-relatives. Participants that employ family members to provide Personal Assistance Services must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews 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. 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. Participants that employ family members to 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.		
C-2-f: Open Enrollment of Providers	All willing and qualified providers have the opportunity to enroll as waiver providers at any time using the following process. OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available	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	COMMCARE, Independence and OBRA	

	upon request from the OLTL, and are also available to potential providers online through the DPW website www.dpw.state.pa.us. For an agency or individual provider to be enrolled as a new service provider they must contact OLTL. OLTL staff will guide the agency or provider of service in preparing an enrollment application. This application must be submitted to the OLTL for approval. The following documents must be completed as part of the enrollment application: 1) Provider Enrollment Information Form 2) Medical Assistance Provider Agreement 3) Rider A to the Medical Assistance Provider Agreement 4) Medicaid Home and Community Based Waiver Program Survey 5) PROMISe Enrollment Form OLTL staff will provide technical assistance to the prospective provider in obtaining the appropriate documentation. Once OLTL receives a completed packet, OLTL staff will send a written response to the prospective provider within 60 days. The written response will include a request for more information, acceptance of enrollment, or denial of enrollment.	website http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm. As a condition of participation in the COMMCARE 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.		
Service Definitions	This section provides definitions, provider qualifications, frequency of verifying provider qualifications and the entities responsible for	Most service definitions were clarified slightly regarding coverage, tie to participant needs as identified in the person-centered plan of care and to	COMMCARE, Independence and OBRA	

	verifying provider qualifications for each of the services offered in the Attendant Care waiver.	make more standardized provider qualifications. Specific services with substantive changes are included in the chart below for review. The following generic provider qualifications were added for most services, with specifically tailored elements to address educational, experience or licensure requirements: Agency: • 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 • Have Professional Liability Errors and Omissions Insurance • Worker's Compensation Insurance, when required by Pennsylvania statute • Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs • Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21 Individual (employed by agency):		

		• 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 or • Complete any necessary pre/in-service training related to the participant's service plan • Receive necessary training to acquire the skill • 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 55 PA Code Chapter 52 Section 52.19 • Have a child abuse clearance (as per 23 PA CS 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 Individual Provider (not employed by agency): • 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 • 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 and child abuse clearances when applicable • Have a child abuse clearance (as per 23 PA CS 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		
General Limitations Language	Each service definition contains limitations on amount, duration and scope. This section also provides expectations regarding coverage from other sources.	To clarify that individuals should access their state plan benefits and other resources in advance of waiver services (to the extent covered/available), added standard language as follows: Services 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. Service 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 Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.		
Personal Assistance Services	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	Definition: 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	COMMCARE, Independence, and OBRA	

		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. Limitations: 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: Residential Habilitation or Respite. (COMMCARE Waiver) Respite. (Independence Waiver) Home Health Care Aide Services, Residential Habilitation, or Respite. (OBRA Waiver) Also, clarifies basic provider qualifications as noted above.		
Community Transition Services	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, OBRA,	

		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. **Limitations:** 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 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 (COMMCARE, Independence, and OBRA Waivers) This service does not cover those services available under Assistive Technology, Home Adaptations and Specialized Medical Equipment and Supplies (Aging Waiver) Also, clarifies basic provider qualifications as noted above.		
PERS	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, and OBRA Waivers	

		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 **Limitations:** 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. Stand-alone 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. Also, clarifies basic provider qualifications as noted above.		
Service Coordination	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, and OBRA Waivers	

		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: o 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. o 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. o Be timely and occur at times and locations of convenience to the participant. o Reflect cultural considerations of the participant. o Include strategies for solving conflict or disagreement within the process. o Offer choices to the participant regarding the services and supports they receive and the providers who may render them. o Inform participants of the method to request updates to the service plan. o 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 HealthChoices 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. **Limitations:** 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. Clarifies basic provider qualifications as noted		

		above		
Supported Employment	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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. **Limitations:** 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	COMMCARE, Independence, and OBRA waivers	

		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. 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. Clarifies basic provider qualifications as noted above.		
Prevocational Services	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE and OBRA waivers	

		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. **Limitations:** 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. Clarifies basic provider qualifications as noted		

		above.		
Home Health Services	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** Home Health Services in the COMMCARE, Independence, and OBRA, waivers consist of the following components: Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy. Home Health Services in the OBRA Waiver also consist of Home Health Aide Services **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	COMMCARE, Independence, and OBRA Waivers	

		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. Nursing Services** 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. Physical Therapy** 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. 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. Occupational Therapy** 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. **Speech and Language Therapy** 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. **Limitations:** 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. Also, clarifies basic provider qualifications as noted above.		

Accessibility Adaptations, Equipment, Technology and Medical Supplies	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	The service is replaced by the following services: Assistive Technology, Home Adaptations, Specialized Medical Equipment and Supplies, and Vehicle Modifications.	COMMCARE, Independence, OBRA, and Aging Waivers	
Assistive Technology		**Definition:** 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	COMMCARE, Independence, OBRA, and Aging Waivers	

		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 • 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. **Limitations:** 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, 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.		
Home Adaptations		**Definition:** 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	COMMCARE, Independence, OBRA, and Aging Waivers	

		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 • 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. **Limitations:** 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. 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. Additional Language in the COMMCARE and OBRA Waivers: This service may not be included on the same service plan as Residential Habilitation.		

Specialized Medical Equipment and Supplies		**Definition:** 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:	COMMCARE, Independence, OBRA, and Aging Waivers	

		• 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. **Limitations:** 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.		
Vehicle Modifications		**Definition:** Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to	COMMCARE, Independence, and OBRA Waivers	

		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 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. **Limitations:** 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.		
Respite	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, and OBRA Waivers	

		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. **Limitations:** 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 Personal Assistance Services or Residential Habilitation (COMMCARE and OBRA Waivers) In-home Respite Services cannot be provided simultaneously with Personal Assistance Services (Independence Waiver) The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan. Clarifies basic provider qualifications as noted above		

Therapeutic and Counseling Services	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence and OBRA Waivers.	

		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. **Limitations:** 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 Waivers.		

		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. Also, clarifies basic provider qualifications as noted above.		
Adult Daily Living	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, OBRA, and Aging Waivers	

		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: • 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 settings for home and community-based waiver services. **Limitations:** 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. Also, clarifies basic provider qualifications as noted above.		
Community Integration	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	Clarifies basic provider qualifications as noted above	COMMCARE, Independence, and OBRA Waivers	
Non-Medical Transportation	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE, Independence, OBRA, and Aging Waivers	

		described in Appendix I.3.g.ii **Limitations:** 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. The Service Coordinator will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of Transportation. 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. (COMMCARE, Independence, and OBRA The frequency and duration of this service are		

		based upon the participant's needs as identified and documented in the participant's service plan. Also, clarifies basic provider qualifications as noted above.		
Residential Habilitation	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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.	COMMCARE and OBRA Waivers	

		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 COMMCARE or 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. **Limitations:** 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. Clarifies basic provider qualifications as noted above		
Structured Day Habilitation	Existing service definition can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	**Definition:** 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	COMMCARE and OBRA Waivers	

		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 the 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. **Limitations:** 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.		

		Clarifies basic provider qualifications as noted above		
Appendix D: Participant Centered Planning				
Appendix D-1-b: Service Plan Development Safeguards	Service Coordination agencies are able to provide Community Transition Services to individuals transitioning from nursing facilities. Participants have the ability to choose from among all willing and qualified providers of Community Transition Services. Service Coordination providers may also provide Financial Management Services to participants. Participants have the ability to choose from among all willing and qualified providers of Financial Management Services. In addition, Service Coordination agencies may serve as an Organized Health Care Delivery System (OHCDS). 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 cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency. Notation is made in the participant's record of receipt of the Service Provider Choice form. Completed forms are maintained in the participant's file with the participant's current	Clarifies services that can be provided by Service Coordination entities and refines description of services that may be rendered as part of an Organized Health Care Delivery System. 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	COMMCARE, Independence and OBRA	

	Service Coordination provider. OLTL monitors receipt of the forms as part of its bi-annual provider reviews. OLTL also provides a toll-free complaint line for participants to report concerns about their provider. This toll-free complaint line information is incorporated into the OLTL Service Provider Choice Form.	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.		
Appendix D-1-c: Supporting the Participant in Service Plan Development	The Individual Service Plan (ISP) development process is a collaborative process between the participant and Supports Coordinator. The participant drives the process and has the right to include family, friends, advocates or others as part of their ISP development. A key step in developing the ISP is to complete the CMI, a standardized needs assessment which identifies the most appropriate services to address the participant's needs. The Supports Coordinator gathers information from the participant, family, friends, advocates or others that are identified and chosen by the participant. 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	Provides additional detail on supports provided to the participant. 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 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	COMMCARE, Independence and OBRA	

	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 meeting(s), the Supports Coordinator collaborates 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). The Service Coordinator assists the participant in the development of the service plan.	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.		
Appendix D-1-d: Service Plan	The individual service plan (ISP), contains essential information about the individual, which	Clarifies expectations and strengthens language regarding the content of the ISP and highlights	COMMCARE, Independence and OBRA	

Development Process	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. Who develops plan and participates in the process: The participant's Service Coordinator develops the service plan utilizing a participant-centered approach. This process involves the Services Coordinator, the participant, and others as identified at the participant's request, such as family members or friends. The Service Coordinator educates the participant about 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 annually with the reevaluation of the participant's needs or more frequently if there is a change in the participant's needs. The Service Coordinator	OLTL-developed standard participant information packet. 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		

	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 needs. The Service Coordinator discusses potential revisions with 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) 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 acts upon the alerts within 14 calendar days. OLTL staff may request additional details or ask for clarification regarding the information that the Service Coordinator provider includes in the HCSIS ISP and comments. If 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.	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		

	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 LOCA tool to determine whether the participant meets the Nursing Facility level of care. In addition a physician completes a prescription indicating the physician's level of care recommendation. At the time of enrollment, the independent enrollment broker completes a standardized needs assessment. The standardized assessment 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 standardized needs assessment annually 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	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,		

	ensure all waiver participants are informed of home and community-based services funded through the [COMMCARE, Independence] 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, Independence] Waiver, to the participant at home visits and through ongoing discussions with the 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. 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, 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	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 [COMMCARE, Independence] 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, Independence] 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**		

	Community Services Information System (HCSIS). All service plan meetings and discussions with the participant are documented in the service notes. The Service Coordinator 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. How responsibilities are assigned for implementing the plan: The Service Coordinator is responsible for developing ISPs and updating annually by performing the following roles in accordance with specific requirements and timeframes, as established by OLTL: • Completing ISPs • Entering ISP's into HCSIS • Updating ISP's 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	**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		

	activities • Completing assessments • Sharing information • Assuring information is in completed ISP • Participating in ISP reviews • Implementing recommended services • Reviewing plan implementation How the process addresses participants' health care needs: The Service Coordinator utilizes information gathered from assessments and discussions with the participant to secure information about the participant's health needs and health status. This information is captured onto a standard service plan form and then documented in the HCSIS. A registered nurse is either on staff with the Service Coordination agency or is available under contract as a nursing consultant to the Service Coordination agency. 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. All service plan meetings and discussions with the participant are documented	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		

	in the service notes. 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 to ensure that there is coordination between services in the ISP, including maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers. OLTL reviews service plans to ensure that non-waiver resources, including MA covered services, are documented on the participant's ISP.	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 assignment of responsibility to monitor and oversee the implementation of the service plan: Upon authorization of the ISP, the Service Coordination agency must provide specific detailed information to service providers of the participant's choice regarding the type, scope, amount, duration, and frequency of the service authorized. Also included should be demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being 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. Service Coordinators are responsible for monitoring 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 wellbeing 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	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		

	(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. The Service Coordinator gathers information on an ongoing basis to assure the ISP reflects the participant's needs. Revisions are discussed with the participant and entered into the ISP in HCSIS and shared with the participant and service providers. OLTL monitors ISPs as part of the annual monitoring for compliance with waiver requirements and ISP policies. OLTL also provides a toll-free complaint line for participants to report concerns about their provider or the delivery of services. The toll-free complaint line information is provided at enrollment, at annual reevaluations, and during OLTL participant service monitoring visits.	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		
Appendix D-1-e: Risk Assessment and Mitigation	The service plan assessment process includes the identification of potential risks to the participant. The Supports Coordinator will discuss these potential risks with the participant and whomever the participant chooses to have present such as the participant's family and	Proves additional detail regarding strategies to identify and mitigate risk as part of the ISP process. The service plan assessment process includes the identification of potential risks to the participant.	COMMCARE, Independence and OBRA	

	friends during the development of the ISP. The Supports 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 will be incorporated into the ISP. The Supports Coordinator will also describe any unique circumstances on the service plan. The Supports Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Supports 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. Currently, 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 Supports 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	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		

	plan fails, participants may utilize the agency model to provide emergency backup coverage to meet their immediate needs. The Supports 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 Supports Coordinators to report disruptions of backup plans and strategies.	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.		
Appendix D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency	OLTL reviews and approves all initial ISPs. The Supports 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 Supports Coordinator submits that potential change to OLTL through the HCSIS. OLTL is responsible for the review and approval of ISP changes in HCSIS. The process of developing and revising service	Provides additional detail around the service plan review process for on-going service plans. 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	COMMCARE, Independence and OBRA	

	plans is monitored by OLTL as listed in the Quality Improvement section of this Appendix.	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.		
Appendix D-2-a: Service Plan Implementation and Monitoring	The Office of Long-Term Living (OLTL) as part of the State Medicaid Agency (SMA) is responsible for oversight of the monitoring and implementation of participant service plans. At time of enrollment, the independent enrollment broker educates participants that they have the right to choose the providers of the services they will receive, including Supports Coordination agencies, and their right to choose a different provider for different services.	Clarifies the role of the SC entity and OLTL role in oversight and monitoring of the ISP. 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	COMMCARE, Independence and OBRA	

	The Supports Coordinator also has a local role in ensuring the implementation and monitoring of the ISP as follows: • Ensures participant choice by providing information on available providers and supports participants in their decisions • Assists participants in gaining access to all necessary services • Works with the participant to identify, coordinate, and facilitate all necessary services • Assists with the coordination of other services from local resources to achieve maximum participant input and support • 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 • Addresses problems and concerns of participants on an as needed basis and report to OLTL with unresolved concerns • Initiates and oversees the process of reevaluation of the participant's level of care and review of ISP • Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP • The supports coordinator asks about and	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: o The participant is receiving the amount, frequency, and duration of services that are in the approved ISP. o The participant is receiving the authorized services that are in the ISP. o The participant is receiving the amount of support necessary to ensure health and safety. o If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes o There is no duplication of services including waiver and non-waiver services. o Contacts with individuals, families and providers. o Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP. o That the recommended and chosen services are being implemented. o 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		

	documents the effectiveness of the participant's back-up plan during monitoring contacts. OLTL monitors for complaints about back-up plans through our complaint database and consumer satisfaction survey for additional information about the effectiveness of back-up plans. OLTL reviews and approves the ISP through the HCSIS. The Supports Coordinator receives an alert of approval or disapproval from OLTL in HCSIS once the ISP is reviewed by OLTL staff. The Supports Coordinator implements services if the ISP is approved by OLTL. Any deficiencies or issues identified through the review of the ISP will be presented to the Supports Coordination Agency for remediation. The Supports Coordinator will be notified through communication from BIS in the comments section of HCSIS. The Bureau of Individual Support will expect the Supports Coordination Agency to outline a plan to correct the issue(s) and submit to BIS 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. The process for trending discovery and remediation information (data) begins with Quality Management, Metrics and Analytics receiving the data from various points in the OLTL system. Database aggregations	• 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.		

	reports are created for QMMA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. Additionally, the QMMA records information from field observations and record reviews to qualify the information gathered via administrative data. QMMA also relies on information provided by local non-state entities and the subsequent review of those entities to identify, track, and trend quality management issues.	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.		
Appendix D-2-b: Monitoring Safeguards	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	Clarifies that Service Coordination Entities have responsibility to monitor service plan implementation and participant health and welfare may provide certain waiver services to the participant through an Organized Health Care Delivery System. 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	COMMCARE, Independence and OBRA	

		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				

E-1-a: Description of Participant Direction	Nature of the Opportunity: All participants have the right to make decisions about and self-direct their own waiver services. Participants may choose to: 1) receive their services through the agency-managed model (Agency Model); or 2) hire and manage staff that performs personal assistance services (Employer Authority Model); or choose a combination of both Agency Model and Employer Authority Model services 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 personal assistant. In the Agency Model, the direct service provider is responsible for hiring, firing, training, scheduling, all payroll tasks, and supervisory activities for each employee. Under the Employer Authority Model, the participant is the employer and is responsible for hiring, firing, training, supervising, and scheduling their personal assistants. How Participants May Take Advantage of Participant Direction: 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 will discuss the available service options and will ensure each participant understands the full range of opportunities with the waiver. The Office of Long Term Living has	**<u>Self-Directed Opportunities Available within the [COMMCARE, Independence, OBRA] Waiver:</u>** All participants in the [COMMCARE, Independence, 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. **<u>How Participants May Take Advantage of Self-Directed Opportunities:</u>** 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	COMMCARE, Independence, OBRA	

	developed standardized educational materials and promotional materials with information about self-direction for all waiver participants. As stated previously, the participant may utilize a combination of any model(s) to personalize their service delivery plan. The ISP is developed in conjunction with the Service Coordinator 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 supports coordinator. Entities That Support Individuals: Participants will receive support from certified Fiscal/Employer Agents and Service Coordinators to assist them in their role as the common-law employer of their workers. The Fiscal/Employer Agents will: • Enroll participants in FMS and apply for and receive Federal and State Authority to act as a Government or Vendor F/EA on behalf of the participant; • Provide participant orientation and skills training 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; effective management of workplace injuries; and informing workers of their right to file	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. **<u>Entities That Support Individuals:</u>** 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		

	unemployment and workers compensation claims when appropriate; • Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards; • Conduct criminal background checks, child abuse clearances when applicable, 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 Service 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 participants in accordance with Pennsylvania workers' compensation insurance law; • Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws; • Process, file and distribute IRS Forms W-2's for all direct care workers and IRS Forms 1099-Misc as applicable, for independent contractors who earn more than $600 in a calendar year; • Assist in implementing the state's quality management strategy related to FMS;	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		

	• Establish and operate a customer service system that effectively serves participants, representatives, care managers/supports coordinators, direct care workers, providers and vendors in an efficient and effective manner. In addition, individuals choosing the Consumer Employer Model will receive assistance from Service Coordinators 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. 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; 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.	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.		
E-1-e: Information Furnished to the Participant	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 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 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. 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	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 everyday 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.	COMMCARE, Independence, OBRA	

	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; • The process for purchasing approved goods and services from vendors, including submitting invoices for payment; • Effective practices for hiring, training, and supervising employees; • The process for resolving issues and complaints; and • The process for reviewing workplace safety issues.	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.		
E-1-f: Participant Direction by a Representative	Waiver services may be directed by a non-legal representative freely chosen by an adult participant: A personal representative will be required for any individual who has impaired judgment as	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	COMMCARE, Independence, OBRA	

	identified on the LOCA and/or 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; and • Be at least 18 years of age. The Service Coordinator may request a personal representative be appointed when circumstances indicate a change in the	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.		

	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. Each personal representative will be required to complete and sign a Personal Representative Agreement form.	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 OLTL Personal Representative Agreement 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 Personal Representative Agreement 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.		
E-1-i-i: Provision of Financial Management Services. Types of Entities.	Currently, waiver participants who self-direct some or all of their services receive Financial Management Services (FMS) as a waiver service from enrolled certified Vendor and Government Fiscal/Employer Agents. OLTL is amending the COMMCARE Waiver to provide FMS as an administrative activity. OLTL has selected one qualified Vendor Fiscal Employer Agents to furnish Financial Management Services to participants across the Commonwealth through a competitive procurement process (RFA). Waiver participants enrolled in the COMMCARE Waiver who self-directs some or all of their services will be transitioned to the selected vendor by January 1, 2013.	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 Human Services 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 [COMMCARE, Independence, OBRA] waiver. One statewide vendor F/EA was selected as a result of the RFA.	COMMCARE, Independence, OBRA	
E-1-i-iv: Oversight of FMS Entities	The statewide vendor 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 Vendor F/EA contract requirements. The Vendor F/EA	Clarifies the OLTL's role in monitoring and providing oversight to the Vendor F/EA 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	COMMCARE, Independence, OBRA	

	FMS provides specific employer agent functions that support the participant with the employer-related functions. Through the OLTL Quality Management and Efficiency Teams (QMET), DPW will conduct a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review is to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. In addition, 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 at a frequency established by DPW. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. SCs will also be required to report any issues with the statewide FMS organization's performance to OLTL. Through the established claims oversight process, OLTL will monitors claim submitted by the Vendor F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.	federal and state law, in accordance with the OLTL Vendor F/EA contract requirements. The Vendor 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 FEA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the FEA and the workers or other vendors. If the FEA is not in compliance with contractual or waiver provisions, OLTL will issue a Corrective Action Plan (CAP). OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition,		

		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. Service Coordinators will 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 toll 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 Vendor F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.		
E-1-j: Information and Assistance in Support of Participant Direction	The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA FMS 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 Department of Human Services issued a Request for Application (RFA) to secure up to three entities that will provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the COMMCARE waiver. One statewide vendor F/EA was selected as a result of the RFA. The selected F/EA organization receives a monthly	COMMCARE, Independence, OBRA	

	The selected Vendor F/EA organization will receive 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 Vendor 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; • The process for purchasing approved goods	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 DHS. 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.		

	and services from vendors, including submitting invoices for payment; • Effective practices for hiring, training, and supervising employees; • The process for resolving issues and complaints; and • The process for reviewing workplace safety issues. Through the OLTL Quality Management and Efficiency Teams (QMET), DPW will conduct a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review is to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. In addition, 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 at a frequency established by DPW. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements.	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, including Services My Way, 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		
Appendix F: Participant Rights				
Appendix F-1: Opportunity to Request a Fair Hearing	Participants are informed at the time of enrollment and at reevaluation that in order to request a fair hearing they should contact their Support Coordination provider. The process is identified on the [COMMCARE, Independence] Signature Page. The local [COMMCARE, Independence] Enrolling Agency and Supports Coordination provider informs participants of the opportunity to request a fair hearing under the provisions of 42 CFR Part 431, Subpart E, to beneficiaries in the following situations: 1. when a participant is not given the choice of home or community-based services as an alternative to the institutional care 2. when a participant is denied the service(s) of their choice 3. when a participant is denied the provider(s) of their choice 4. any actions to deny, suspend, reduce, or terminate services 5. An individual also has the right to appeal the local Attendant Care Enrolling Agency's or Supports Coordination provider's failure to act per the Regulations at 55 PA Code §275.1(a) (i) (E). These regulations state that an individual may appeal an "undue delay in making a payment adjustment or acting upon a request or application."	Clarifies language that describes the procedures for advising individuals of fair hearing rights. 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.		

	Initially, the local [COMMCARE, Independence] Enrolling Agency must send a written notice to the individual when the individual is found ineligible for services. When a participant is determined to be likely to require a level of care as indicated in the [COMMCARE, Independence] Waiver, the local [COMMCARE, Independence] Enrolling Agency will inform the participant or his or her legal representative of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services. The local [COMMCARE, Independence] Enrolling Agency issues a Notification of Eligibility Determination form to notify the participant of their right to a fair hearing and instructions on how the participant may request a fair hearing. The local [COMMCARE, Independence] Enrolling Agency retains copies of written notices at the local level. Ongoing, the Supports Coordination provider must send a written notice to the individual when services are denied, suspended, reduced, or terminated. The Supports Coordination provider is responsible to provide the participant with at least ten days advance notice when an action will be taken regarding existing services that is subject to appeal. If the participant files an appeal prior to the date the action is to become effective, the services must continue pending the resolution of the appeal. If advance notice is not provided, the participant has the right to maintain services at the current level if the appeal request is made within ten days of	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		

	the participant being informed of the action. A service that is denied prior to being included on an authorized service plan can be appealed, but is not subject to the continuation pending the appeal. The Supports Coordination provider retains copies of written notices at the local level The Department of Public Welfare (the State Medicaid Agency) operates a comprehensive hearings and appeals process through the Bureau of Hearings and Appeals. When an appeal is received by the Bureau, it is docketed and scheduled for a hearing to be conducted by an Administrative Law Judge. When a hearing date has been assigned, a written notice is sent to both parties, i.e. the appellant and to the departmental program office. Either party to an applicant or recipient appeal may seek reconsideration by the Secretary of Public Welfare of the final order of the Director of the Bureau by requesting such within 15 calendar days from the date of the final order. Title 55 PA Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department." This includes local [COMMCARE, Independence] Enrolling Agencies and Supports Coordination providers.	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		

	Local [COMMCARE, Independence] Enrolling Agencies and Supports Coordination providers are responsible for ensuring that individuals receive whatever help is needed to fill out and file the appeal form [see 55 PA Code §275.4(a)(1)].	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-3-c: Description of System	The OLTL operates a Hotline # 1-800-757-5042. The hotline provides general eligibility requirements and information and referral for OLTL waivers and programs to the general public, potential applicant or participant/	Clarifies the complaint resolution process. 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 family. All Hotline calls are responded to within one (1) business day. Calling the hotline is not a prerequisite for the participant to request a fair hearing. Participants are informed and notified of their right to appeal as a separate process from the hotline. The types of complaints that can be addressed are: • Complaints/grievances regarding provision and timeliness of services • Reports of alleged abuse, neglect, or exploitation • Status of waiver or program eligibility The process used for operation of the complaint system: OLTL takes calls on the toll free line. The OLTL call taker enters call information into the tracking data base. The OLTL call taker forwards grievances and complaints immediately to the appropriate OLTL Program Specialists for follow-up, research, and resolution. This information is also tracked in the data base. At a minimum, OLTL will initially respond to grievance and complaint calls within one business day. Additional follow-up and resolution timelines may vary depending on the issue or issues to be resolved. Reports of potential abuse/neglect and the use of restrictive interventions and restraints are	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		

	followed up in accordance with OLTL Policy as outlined in Appendix G-1 and G-2. OLTL maintains a log to assure timely follow-up and unresolved issues are discussed and reviewed for resolution by appropriate OLTL staff. OLTL staff reviews all pertinent information with the participant, other OLTL staff, providers, or others as identified by the participant in order to resolve such complaints/grievances; at risk participant issues, and/or program issues as they arise. Supports Coordination providers inform and notify participants that their right to appeal is a separate process from calling the toll free hotline. Supports Coordinators share this information during home visits and through ongoing discussions with the participant.	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-b: State Critical Event or Incident Reporting Requirements	The Office of Long Term Living is involved with the following efforts to assure that critical events or incidents are reported in the [COMMCARE, Independence] waiver. 1. Pennsylvania Act 28, "Neglect of Care Dependent Persons," provides protection for individuals age 18 and older who, due to physical or cognitive disability or impairment, require assistance to meet their needs for food, shelter, clothing, personal care or health care. The Act states that a caretaker who intentionally causes bodily injury to a care-dependent person by failure to provide treatment or services necessary to preserve a care dependent person's health and safety, or who intentionally uses a physical or chemical restraint or isolates that person resulting in bodily injury, may be prosecuted under the Act. "Care dependent person" is defined as any adult who, due to physical or cognitive disability or impairment, requires assistance to meet their needs for food, shelter, clothing, personal care or health care. Specified violations of the Act may be punished as a felony of the first degree with a term of imprisonment of not more than 20 years. A caretaker is defined as, among other things, any person who has an obligation to care for a care-dependent person in the care-dependent	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 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,	Attendant Care, COMMCARE, Independence and OBRA	

	person's home for monetary consideration. People who must report incidents under the Act include personnel of the Department of Aging (or Area Agencies on Aging), Department of Health, or Department of Public Welfare when they have reasonable cause to believe that a care-dependent person has suffered bodily injury or been restrained in violation of the Act. Reports must be made immediately to the local law enforcement agency or to the Pennsylvania Office of the Attorney General. Section V.6.4 of the "Attendant Care Program Requirements" manual issued by the Department of Public Welfare in 2002 states that providers must give training on the provisions of Pennsylvania Act 28. A copy of the Act is also included in the manual. This manual outlines overall policies for the Attendant Care waiver and is distributed to all providers in the program. It is divided into seven chapters covering the history, administration, program and financial eligibility, services, participant rights and a glossary of terms. 2. Pennsylvania Act 13 requires an employee or administrator of a facility (including a home health agency) who has reasonable cause to suspect that a recipient is a victim of abuse to immediately report the abuse. For the Attendant Care Waiver, Act 13 applies when the Personal Assistance Worker is an employee of a home health agency.	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		

	Within 48 hours of making all oral reports, the employee or administrator shall make a written report (on forms prescribed by PDA as mandated by Act 13) to the AAA. Additionally, within 48 hours of making an oral report for an abuse involving sexual abuse, serious physical injury, serious bodily injury and suspicious death, the employee and an administrator shall make a written report (on forms prescribed by PDA as mandated by Act 13) to appropriate law enforcement officials. The AAA will forward a copy of the written report to the Department of Aging within 48 hours for all reports involving sexual abuse (not including sexual harassment), serious physical injury, serious bodily injury and suspicious death. A "recipient" is defined as any individual who receives care, services or treatment in or from a facility (regardless of age). The following types of incidents must be reported: Abuse: The occurrence of one or more of the following acts: (1) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; (2) the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; (3) sexual harassment; and/or (4) sexual abuse which is intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault or incest.	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. Participants, families or other interested parties may also report critical incidents by calling the OLTL toll free Participant Helpline. Hotline staff collect incident information and enter it into the electronic system and the incident is reviewed by staff and assigned to Bureau of Participant Operations (BPO) staff for investigation and action. 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		

	Serious Bodily Injury: An injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ. Serious Physical Injury: An injury that causes a person severe pain or significantly impairs a person's physical functioning, either permanently or temporarily. Sexual Abuse: Intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest. 3. Additionally, the Office of Long Term Living maintains a statewide toll free number that has been widely publicized to program participants, attendants, providers, legal representatives and family members. The participant enrollment form, which is required under the program, and a participant handbook, contain the toll free number. This allows participants, attendants, and other individuals (e.g., family members, neighbors, provider employees) to report incidents of abuse, neglect and exploitation of participants in the [COMMCARE, Independence] waiver. 4. The enrolling agency reviews a standardized form with the participant during enrollment and at reevaluation. The process for reporting	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 agency, or facility is providing services; • Critical incidents that occur during the time the agency, or facility is contracted to provide services, but fails to do so; and • Critical incidents that occur at times other than when the agency or facility 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		

	health and safety concerns is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns. There are currently no specified time frames in which the Supports Coordinator must respond -- other than those required under Acts 13 and 28. Further development of critical incident reporting and monitoring, and efforts to provide education are outlined in the Health and Welfare section of the work plan.	OLTL, and Service Coordination Entities when applicable, within 4824 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		
Appendix G-1-c: Participant Training and Education	Currently approved waiver did not address this area.	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	Attendant Care, COMMCARE, Independence and OBRA	

		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.		
Appendix G-1-d: Responsibility for Review of and Response to Critical Events or Incidents	Currently approved waiver did not address this area.	**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	Attendant care, COMMCARE, Independence and OBRA	

		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 is responsible to 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- The provider and/or the participant onsite visit is conducted for fact finding. The incident facts, sequence of events,		

		interview of witnesses and observation of the participant and/or environment is required. • 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 2. Preventative action through the service plan is implemented and documented 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.		
Appendix G-1-e: Responsibility for Oversight of Critical Incidents and Events	The Office of Long-Term Living maintains a statewide database on all participants who were referred for investigation of an incident. Reports related to incidents are run monthly, quarterly and annually. The results are aggregated for tracking and trending purposes to detect patterns for possible remediation. The results of the reports are presented at the Quarterly Quality Management Meetings (QM2) and the Quality Council which meeting quarterly to discuss and recommend quality improvement measures.	OLTL 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, DHS' Adult Protective Services 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	Attendant Care, COMMCARE, Independence and OBRA	

		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: Restraints or Seclusion and G-2: Restrictive Interventions	The enrolling agency reviews a standardized form with the participant during enrollment and at reevaluation. The process for reporting the use of Restraints and Restrictive Interventions is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns. The Office of Long Term Living is notified about unauthorized use or restraints or seclusion through the Supports Coordination providers and participants. OLTL provides a toll free number for agencies and individuals to register a complaint. The participant enrollment form and handbook contain the toll free number. 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 or seclusion, OLTL requires all Supports Coordination providers to annually provide staff training on detection and prevention of abuse and neglect including the use of restraints.	The enrolling agency reviews a standardized form and the participant waiver manual during enrollment and at reevaluation. The process for reporting the use of Restraints and Restrictive Interventions is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns. The Office of Long Term Living is notified about unauthorized use or restraints or seclusion through the Supports Coordination providers and participants. The incident reporting process (including EIM) has a secondary category which identifies restrain use. So if a death, hospitalization or serious injury, etc. is a result of the restrain use OLTL is aware and ensures appropriate intervention. OLTL provides a toll free number for agencies and individuals to register a complaint. The participant enrollment form and handbook contain the toll free number as well as notice regarding the prohibition regarding use of restraints. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken,	COMMCARE, Independence, OBRA	

	Further development of reporting and monitoring on use of restraints and education on this topic are outlined in the Health and Welfare section of the work plan.	including notification of the local law enforcement agency. To assist in the detection of the unauthorized use of restraints or seclusion, OLTL requires all Supports Coordination providers to annually provide staff training on detection and prevention of abuse and neglect including the use of restraints.		
Appendix G-3-b-i Medication Management and Follow-Up: Responsibility	As outlined in C-3, Registered nurses from the service coordination agencies provide assistance in reviewing medication regimens for individuals during quarterly face-to-face monitoring visits using a standard monitoring tool. They can use the OLTL regional team staff for support with regard to questions about medications. Regional teams have access to nurses or the OLTL medical director to help with questions about medications. Service coordination agencies monitor medication logs to ensure medications are provided appropriately and that any errors were reported to the licensing entity and OLTL as an incident. QMETs review to ensure providers have the appropriate licensure which includes medication management.	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	COMMCARE, OBRA	

		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		
Appendix G-3-b-ii Methods of State Oversight	Through the Office of Medical Assistance Programs each participant's medications are reviewed at the time of refill or addition of a new medication via a standard pharmacy program to look for problems like therapeutic duplication, prescribed allergic medications, dosages over the recommended level, concurrent use of contraindicated medications, etc. The pharmacist contacts the prescribing practitioner if a potential problem before filling the prescription. This information is reviewed through a Drug Utilization Review both prospectively and retrospectively and findings are communicated to healthcare practitioners either collectively thru Continued Medical Education (CME) or individually. In addition to the pharmacist contacting the prescribing practitioner, patterns of potentially harmful practices are communicated to the practitioner community via	OLTL uses the DHS 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. The course	COMMCARE, OBRA	

	remittance advices and CME addressing the particular issue. Medication errors for individuals residing in personal care homes are reportable incidents as outlined in G-1-b.	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 48 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 ot 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		
Appendix G-3-c-ii Medication Administration by Providers	State regulations for community homes and day programs allow for the administration of medication by unlicensed staff when trained using a standard Medication Administration course. The current medication administration course requires the review of medication administration logs for errors in documentation including matching the person's prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff are not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self administration guidelines appear in the regulations and setting up and monitoring self administration programs are taught as part of the medication administration program. These requirements do not apply to non-licensed providers. Medications are also monitored by service coordination agencies as part of their routine monitoring of waiver services. Service coordination agencies monitor medication logs to ensure medications are provided appropriately and that any errors were reported to the licensing entity and OLTL as an incident.	**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 DHS-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	COMMCARE, OBRA	

		administration, and the training required for provider staff to administer medication. <u>Self-Administration.</u> (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 DHS-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. <u>Medication Administration Training</u> (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.		
Appendix G-3-c-iii Medication Error Reporting	The Department of Public Welfare, via an electronic database, HCSIS which is accessible by the state and providers. Providers record medication errors including wrong person, wrong medication (wrong medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position. Providers report medication errors including wrong person, wrong medication (wrong	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 48 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin. EIM is accessible to the state, Service Coordinators and providers. 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	COMMCARE, OBRA	

	medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position.	medication at the prescribed time, administration to the wrong person, and administration through the wrong route. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 48 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin.		
Appendix G-3-c-iv State Oversight Responsibility	Annual licensing inspections monitor medication administration through standardized reviews of licensed services. Service coordinators monitor medications for individuals. The required medication administration course teaches problem solving and has been modified to address problems identified through data captured. Any medication error leading to hospitalization, emergency room visit, etc. is reviewed in depth with the potential for investigation by the licensing entity. Medication errors are also reported to OLTL through the incident reporting policy and investigated by QMMA consistent with the procedures outlined in G-1-d. OLTL reviews lead to changes in the medication administration instrument and additional training.	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 DHS 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.	COMMCARE, OBRA	

QIS: Discovery, Remediation and Appendix H: Systems Improvement				
Overview	Existing performance measures and systems improvement strategy can be found in the approved waiver at: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm	The overall quality improvement strategy provides a comprehensive description of the discovery, remediation and systems improvement process that OLTL utilizes to oversee the waiver and to ensure compliance with all CMS-required statutory assurances, including the health and welfare of waiver participants. Performance measures have been updated to reflect March 12, 2014 guidance from CMS which modifies the quality assurance system and related assurances/subassurances. The revised performance measures and systems improvement strategy can be found in Appendix H/QIS section of the proposed waiver renewals and amendments. Language can be found at [insert link]	Aging, Attendant Care, COMMCARE, Independence, OBRA	
Appendix I: Financial Accountability				
I-1: Financial Integrity and Accountability	The following are the audit and financial review requirements to ensure the financial integrity of the waiver program. 1. Providers and recipients who are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502 as amended, are also required to complete the Department of Public Welfare's (DPW) annual Single Audit Supplement publication. DPW releases an annual Single Audit Supplement publication to county government and CPA firms. It provides compliance requirements specific to DPW	Clarifies providers are subject to requirements specified in 55 PA Code Ch. 52. 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)	COMMCARE, Independence and OBRA	

	programs, including waiver services. The waiver services are tested in accordance with both the compliance requirements set forth by the OMB Circular A-133 compliance supplement and by the DPW single audit supplement. These procedures are applicable to both public and private organizations providing waiver services that are subject to the Single Audit Act of 1984, P.L. 98-502 as amended. The Single Audit Act Supplement fulfills four basic needs: a. A reference manual detailing additional financial and compliance requirements pertaining to specific DPW program operated by local governments and/or private agencies; b. an audit requirement to be referenced when contracting for single audit services, providing the auditing entity with the assurance that the final report package will be acceptable to DPW; c. a reporting document for passing compliance requirements to a lower tier agency; d. additional guidance to be used in conjunction with Single Audit as amended, OMB Circular A-133, Government Auditing Standards (commonly known as the "Yellow Book") issued by the Comptroller General of the United States; OMB Federal Compliance Supplement, and audit and accounting guidance issued by the	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. For those providers 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		

	AICPA. 2. For those providers which are not required to receive a single audit, DPW may request the provider have the provider's auditor perform an attestation engagement including an audit in accordance with any of 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. A provider 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 fical year-end, whichever is greater. 3. If issues of financial fraud and abuse are suspected, OLTL through the DPW Office of General Counsel (OGC) will refer such issues to the DPW Office of Medical Assistance Programs (OMAP), Bureau of	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		

	Program Integrity (BPI) for review, investigation, and appropriate action. 4. OLTL staff also conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. OLTL reviews 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 reviews, remediation may include: • OLTL monitoring and training of provider staff in proper documentation of services rendered • Time-limited monitoring by Service Coordinator or Service Coordinator Supervisor of weekly time sheets submitted by staff or recipient of service agency • Suspension of new provider enrollment • Termination of waiver provider agreement • Provider refund of inappropriately billed amounts	• 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.		
I-2-a: Rate Determination Methods	Rates for adult daily living, clustered shared living, community integration, home health services, personal assistance services, prevocational services, residential habilitation, service coordination, respite, structured day habilitation, supported employment, and therapeutic and counseling services are developed through a market-based methodology. Relevant market information is gathered from multiple sources including but not limited to Bureau of Labor Statistics salary	Provides additional detail regarding the process for establishing rates. 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	COMMCARE, Independence and OBRA	

	information, other state's rate information, similar program information including Medicare and Medicaid fee schedules. This information is used to create base assumptions in the rate model. Provider cost information is collected through a cost survey to validate assumptions for the cost components of the services (i.e. staffing cost, productivity, indirect costs, etc.) The purpose of the provider information is to inform the assumptions built into the rate methodology and not serve as the quantitative basis for the assumptions. The rates are applicable to all providers, with the rates varying by geographic region. Rates for Financial Management Service were established as follows: • One-time Per Participant Start-up Fee - using a market-based methodology, the one-time per participant start-up fee was developed based upon information provided by the current F/EAs which pertained to the estimated costs and percentage of time needed to provide new participant orientation, enroll the participant with the F/EA and enroll direct care workers. The average length of time reported to complete all components of these three tasks was multiplied by Total Staff Compensation Costs, which accounts for F/EA staff, Supervisory staff wages, and non-productive time. The current per member per month fee was then added to the best estimate rate. • One-time Per Participant Transition Fee -	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: o Wages for staff o Employee-related expenses o Productivity o Program Indirect expenses o 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 assistant services, service coordination, and transition service coordination. • Additionally, OLTL reimburses the following services: Community Transition Services, Participant Directed Community Supports, Participant Directed Goods and Services and Personal Emergency Response System based on the cost charged to the general public for the		

	using a similar method as above, the one-time per participant transition fee was based upon gathering participant information from the current F/EA via an electronic file transfer; loading the data into the new vendor's IT system; checking to ensure all required information is received and following up to gather missing documentation as necessary; and securing a new IRS Form 2678. This is primarily data-entry work. The estimated length of time needed to complete these tasks was multiplied by the calculated F/EA Staff Hourly Compensation cost. • Administrative Per Member Per Month Fee - the per member per month fee was established through the competitive procurement process. The cost survey and rate model have been developed with input from representative stakeholders including consumers, providers, service coordination agencies, provider associations and consumer advocacy organizations. Additionally, prior to the effective date of rates, the rates and the methodology for calculating rates are communicated to the provider in a public notice published in the Pennsylvania Bulletin. OLTL reimburses the following services: Accessibility Adaptations, Community Transition Services, Durable Medical Equipment and Supplies, Non-Medical Transportation, and Personal Emergency Response System based	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. 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.		

	on the cost charged to the general public for the good or service. Claims are processed through PROMISe which is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS). Claims and payments are monitored by OLTL through the use of PROMISe and HCSIS generated reports. 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.			
I-2-b: Flow of Billings	Providers are enrolled as Medical Assistance providers. Providers are reimbursed retrospectively based on services provided. Providers submit claims to the Office of Medical Assistance Programs through PROMISe. PROMISe verifies participant information in the Client Information System (CIS), 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 waiver program.	Providers must follow PA Code Chapters 52 and 1101 when submitted 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	COMMCARE, Independence and OBRA	

		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. Billings for recipients that choose to self direct their services is more fully outlined in Appendix E. For Consumer Directed Personal Assistance Services, the Fiscal Employee Agent 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.		
I-3-g-ii: Organized Health Care Delivery System	The Office of Long Term Living (OLTL) established an Organized Health Care Delivery System (OHCDS) that includes Service Coordination Agencies. OHCDS	Provides additional detail of the role of an OHCDS. a. Entities eligible for designation as OHCDS for services within this waiver are service	COMMCARE, Independence and OBRA	

	enrollment is voluntary and requires member agencies to sign an agreement with OLTL. OLTL conducted a survey of enrolled Service Coordination Agencies to identified interested agencies. Members of the OHCDS are able to subcontract with providers of Accessibility Adaptations, Equipment, Technology and Medical Supplies, Community Transition Services, Personal Emergency Response (PERS), and Non-Medical Transportation services. Providers are encouraged to enroll as Medical Assistance Providers and bill the state directly. In order to become an OLTL Waiver Provider, applicants complete a PROMISe Provider Enrollment Base Application along with all applicable documentation for the specific service. Enrollment information is obtained on the OLTL website or by contacting the Bureau of Provider Supports. Waiver participants are given a choice of all enrolled and subcontracted providers through the standardized provider choice form. Members of the OHCDS are responsible for ensuring that their subcontractors meet the provider qualifications contained in the Waiver. The QMET monitor member organizations every two years to ensure that their subcontractors meet the qualifications and that reimbursement for the services is at cost.	coordination entities, all of which render at least one Medicaid service directly (SC). 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, and f. That 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		

I-3-g-ii: Method for Excluding the Cost of Room and Board Furnished in Residential Settings	The State assures CMS that payments are not made for room and board except as explicitly allowed in 42 CFR § 441.310 (a) (2), which permits room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence. Room and board costs are excluded from respite services when the service is provided in a setting that is not facility-based. OLTL requires providers to utilize OLTL's rate setting methodology in the determination of rates for waiver services. This includes the use of a standardized cost survey and instructions that establishes rates for residential waiver services. The cost report calculates both waiver eligible and ineligible costs for residential services. The cost survey is formatted to allow room and board costs to be entered as part of the ineligible costs only; room and board costs cannot be entered as part of eligible costs on the cost report. Completion of the cost survey results in an eligible rate.	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.	COMMCARE, OBRA		
Appendix J: Cost Neutrality					
J-1 Derivation of Estimates	Reflects the number of individuals s expected to be served for each year of the waiver, the associated costs for serving individuals and the methodology used to calculate costs.	Clarifies the data sources used to make utilization projections and revises methodology for projecting institutional costs.	COMMCARE, Independence		