

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Pennsylvania** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**

OBRA Waiver

C. **Waiver Number: PA.0235**

Original Base Waiver Number: PA.0235.

D. **Amendment Number: PA.0235.R04.05**

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

07/01/15

Approved Effective Date: 10/28/15

Approved Effective Date of Waiver being Amended: 07/01/11

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Several changes have been included in this application to amend the OBRA Waiver. The purpose of these changes is to:

- Submit OLTL's waiver-specific HCBS transition plan for the OBRA waiver;

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C – Participant Services	
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	
<input checked="" type="checkbox"/> Appendix H	

<input checked="" type="checkbox"/> Appendix I – Financial Accountability		
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration		

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications Revise
- provider qualifications Increase/decrease
- number of participants Revise cost
- neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Revises the performance measures and quality improvement strategy throughout the waiver

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State of Pennsylvania** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

OBRA Waiver

C. Type of Request: amendment

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

- 3 years 5 years

Original Base Waiver Number: PA.0235

Waiver Number:PA.0235.R04.05

Draft ID: PA.037.04.05

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

Regular Waiver ▼

E. Proposed Effective Date of Waiver being Amended: 07/01/11

Approved Effective Date of Waiver being Amended: 07/01/11

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- Hospital**

Select applicable level of care

- Hospital as defined in 42 CFR §440.10**

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

- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

- Nursing Facility**

Select applicable level of care

- Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

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

Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)

1. Request Information (3 of 3)

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

Select one:

- Not applicable
- Applicable

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
- Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.

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

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

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

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the

number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The Office of Long-Term Living (OLTL), in accordance with the public input provisions found at 42 C.F.R. §441.304 (f) (1) – (f) (3) of the Home and Community-Based Services (HCBS) Settings regulations, conducted a 45-day public input process to
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Allen

First Name:

Leesa

Title:

Executive Medical Assistance Director

Agency:

Department of Human Services

Address:

625 Forster Street

Address 2:

331 Health & Welfare Building

City:

Harrisburg

State:

Pennsylvania

Zip:

17120

Phone:

(717) 787-2600

Ext:

TTY

Fax:

(717) 772-2062

E-mail:

lallen@pa.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Pennsylvania

Zip:

Phone:

Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Virginia Brown

State Medicaid Director or Designee

Submission Date:

Oct 19, 2015

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

Last Name:

Allen

First Name:

Leesa

Title:

Executive Medical Assistance Director

Agency:

Department of Human Services

Address:

625 Forster Street

Address 2:

331 Health and Welfare Building

City:

Harrisburg

State:

Pennsylvania

Zip:

17120

Phone:

(717) 787-2600 Ext: TTY

Fax:

(717) 772-2062

E-mail:

Attachments

lallen@pa.gov

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

1. The state increased the number of required services monthly from one (1) to two (2) - see Appendix B-6-a-i. No participants currently receiving services in the OBRA Waiver will be affected by this change as no participants are currently receiving only one

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

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

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

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

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

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

OBRA Waiver

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I.3.d Additional Information

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

Office of Long-Term Living

(Complete item A-2-a).

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

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

OLTL retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

As noted above, OLTL retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

OLTL retains the authority over the administration of the OBRA Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

OLTL remains the ultimate authority for Waiver policies, rules, and regulations; and retains the ultimate authority on all administrative decisions. OLTL retains the responsibility for supervision and assessment of the performance of AAAs and

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

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

Where possible, include numerator/denominator.

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

Performance Measure:

AA-1: Number and percent of AAAs that meet waiver obligations regarding initial level of care determinations
Numerator: Total number of AAAs who meet contractual obligations regarding initial level of care determination
Denominator: Total number of AAAs reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Other
Specify:

Annually

Stratified
Describe Group:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95% + - 5%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Bi-annual QMET monitoring review"/>	

Data Aggregation and Analysis:

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

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

Performance Measure:

AA-2: Number and percent of Service Coordination agencies that meet waiver obligations regarding ongoing level of care determinations
Numerator: Number of SCEs reviewed who met waiver obligation regarding ongoing level of care determination
Denominator: Total number of SCES reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

AA-3: Number and percent of contractual obligations met by the Independent Enrollment Broker

Numerator: Total number of contractual obligations that were met by the IEB Denominator: Total number of contractual obligations of the IEB

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Bi-Annual QMET monitoring review"/>	

Data Aggregation and Analysis:

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

Performance Measure:

AA-5: Number and percent of contractual obligations met by the FEA. Numerator: Number of contractual obligations that were met by FEA. Denominator: Total number of contractual obligations of the FEA

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Other
Specify:

Annually

Stratified
Describe Group:

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

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95% + - 5%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Bi-annual QMET monitoring review"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

AA-6: Number and percent of contractual obligations met by the FEA regarding the execution of Medicaid provider agreements. Numerator: Number of contractual obligations met by the FEA regarding the execution of Medicaid provider agreements Denominator:m Total number of contractual obligations of the FEA regarding the execution of Medicaid provider agreements

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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Performance Measure:

AA-7: Number and percent participant distribution by # of participants and by % by region within the income limits applicable to the waiver Numerator: Participants in the waiver within the income limits applicable to the waiver Denominator: Total regional population within the income limits applicable to the waiver

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

AA-8: Number and percent of providers that comply with HCBS setting requirements
Numerator: Number of providers that comply with HCBS setting requirements
Denominator: Total number of providers

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Other

Specify:

[Empty text box for specifying other details]

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

The Quality Management Efficiency Teams (QMETS) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETS are comprised of one Program Specialist (regional team lead), one Registered Nurse,

b. Methods for Remediation/Fixing Individual Problems

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

When the administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

[Empty text box for providing detailed strategy and timeline]

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit

<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	18	59	<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. *Complete Items B-2-b and B-2-c.*

The cost limit specified by the State is (*select one*):

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost

limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1694
Year 2	1694
Year 3	1694
Year 4	1694
Year 5	1694

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	0
Year 2	1586
Year 3	1586
Year 4	1586
Year 5	1586

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes	
Nursing HomeTransition/ Money Follows the Person	-

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Nursing HomeTransition/ Money Follows the Person

Purpose (*describe*):

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the OBRA Waiver to serve participants in the demonstration. MFP participants will

Describe how the amount of reserved capacity was determined:

Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	23
Year 2	23
Year 3	23
Year 4	23
Year 5	23

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

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:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- No
- Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that

may receive services under this waiver)

Specify:

All other mandatory and optional groups under the State Plan are included.

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to

the 42 CFR §435.217 group.

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

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

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.**

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

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

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (select one):

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

(Complete Item B-5-b (SSI State) and Item B-5-d)

- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

- b. **Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. **Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan**

Select one:

- SSI standard**
 Optional State supplement standard
 Medically needy income standard
 The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
 A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

- Other**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable**

- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
 Optional State supplement standard
 Medically needy income standard
 The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
 AFDC need standard
 Medically needy income standard
 The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
 The State does not establish reasonable limits.
 The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
 Optional State supplement standard
 Medically needy income standard
 The special income level for institutionalized persons

- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:**

Specify formula:

- Other**

Specify:

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
 The State does not establish reasonable limits.
 The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

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

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

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

- Other**
Specify:

The Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. In addition a physician (M.D or D.O) completes a level of care recommendation.

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

AAA Assessors

One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Initial Level of Care Evaluation:

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

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months**
 Every six months
 Every twelve months
 Other schedule

Specify the other schedule:

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
 The qualifications are different.

Specify the qualifications:

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

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

On an annual basis from the date the initial evaluation is completed the Service Coordinator will meet with the participant in their home to reassess the participant's need for waiver services and complete the Reassessment Summary Form. One month

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

LOC-1: Number and percent of all new enrollees who have an initial level of care determination that adhered to timeliness and specification prior to receipt or waiver services.

Numerator: Total number of initial LOC determinations that adhered to timeliness and specification prior to receipt or waiver services. Denominator: Total Number of all new enrollees

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Continuously and

Other

	Ongoing	Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="SAMS report"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

LOC-2: Number and percent of annual LOC reevaluations that adhered to timeliness and specifications
Numerator: Number of annual LOC reevaluations that adhered to timeliness and specification
Denominator: Total number of waiver participants reviewed

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

/ The Level of Care Sub-assurances are monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. The

b. Methods for Remediation/Fixing Individual Problems

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

If the BQPM’s review of LOC data in the case management or Retrospective Service Plan Review tracking systems identifies non-compliance regarding the timeliness or specifications of initial or annual LOC reassessments, a Quality

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PARTICIPANT FREEDOM OF CHOICE

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Service Coordination Entities and Direct Service 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

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service	-	-
Statutory Service	Adult Daily Living		
Statutory Service	Education		
Statutory Service	Personal Assistance Services		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation Services		
Statutory Service	Respite		
Statutory Service	Service Coordination		
Statutory Service	Structured Day Habilitation Services		
Statutory Service	Supported Employment		
Extended State Plan Service	Home Health Services		
Supports for Participant Direction	Financial Management Services		
Other Service	Accessibility Adaptations, Equipment, Technology and Medical Supplies		
Other Service	Assistive Technology		
Other Service	Community Integration		
Other Service	Community Transition Services		
Other Service	Home Adaptations		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response System		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Therapeutic and Counseling Services		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

Adult Daily Living

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are necessary, as specified by the service plan, to enable

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

Adult Daily Living services may only be funded through the waiver when the services are not covered by the State Plan, or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center
Agency	Older Adult Daily Living Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Daily Living

Provider Category:

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications

License (specify):

Meet licensing regulations under Title 55 PA Code, Chapter 2380, Subchapter A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS, Office of Administration, Bureau of Human Services Licensing
OLTL

Frequency of Verification:

DHS - Annually
OLTL - At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Daily Living

Provider Category:

Agency ▼

Provider Type:

Older Adult Daily Living Center

Provider Qualifications

License (specify):

Meet licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Aging
DHS, Office of Long-Term Living, Bureau of Quality and Provider Management

Frequency of Verification:

Department of Aging - Annually
Bureau of Quality and Provider Management - At least every 2 years and more frequently when deemed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Education ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

17 Other Services ▼

Sub-Category 1:

17990 other ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

EDUCATION SERVICES ARE NO LONGER AVAILABLE IN THE OBRA WAIVER EFFECTIVE JUNE 1, 2012. ▾

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

EDUCATION SERVICES ARE NO LONGER AVAILABLE IN THE OBRA WAIVER EFFECTIVE JUNE 1, 2012. ▾

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Education Instructor
Agency	School or Facility Program approved by the Department of Education to provide Education Services

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Education

Provider Category:

Individual ▼

Provider Type:

Independent Education Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified through the Department of Education

Other Standard *(specify):*

The individual education instructor must meet the following:
• Be age 21 or older

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Every Two Years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Education

Provider Category:

Agency ▼

Provider Type:

School or Facility Program approved by the Department of Education to provide Education Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified through the Department of Education

Other Standard *(specify):*

The individual education instructor and those individuals employed by the agency must meet the following:
• Be age 21 or older

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Every Two Years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Personal Care ▼

Alternate Service Title (if any):

Personal Assistance Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services ▼

Sub-Category 1:

08030 personal care ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

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

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

Personal Assistance Services may only be funded through the waiver when the services are not covered by the State Plan, EPSDT, or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Individual Support Service Worker

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistance Services

Provider Category:

Agency ▼

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

Agency:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/ Department of Health

Frequency of Verification:

At least every two years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistance Services

Provider Category:

Individual ▾

Provider Type:

Individual Support Service Worker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Support Service workers must:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent/OLTL

Frequency of Verification:

At least every two years and more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Prevocational Services ▼

Alternate Service Title (if any):

Prevocational Services

HCBS Taxonomy:

Category 1:

04 Day Services ▼

Sub-Category 1:

04010 prevocational services ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Prevocational services are services not available under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the individuals with Disabilities Education Act of 1973 [20 U.S.C. 1201 (16 and 17)]. Services are aimed at

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency Provider

Type: Vocational

Facility

Provider Qualifications

License (specify):

55 PA Code Chapter 2390

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS and OLTL

Frequency of Verification:

DHS – Annually

OLTL – At least every two years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation Services

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

_____ ▼ | _____ ▼

Service Definition (Scope):

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

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

Payment is not made for room and board.
Residential Habilitation services do not include the provision of a structured day habilitation, adult daily living,

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Residential Habilitation Provider
Agency	Unlicensed Residential Habilitation Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation Services

Provider Category:

Agency ▼

Provider Type:

Licensed Residential Habilitation Provider

Provider Qualifications

License (specify):

Licensed by the PA Department of Public Welfare, per 55 PA Code 2600, Personal Care Homes

Certificate (specify):

By July 1, 2014 those providing residential rehabilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (adult) accreditation

Other Standard (specify):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/OLTL

Frequency of Verification:

DHS – Annually

OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation Services

Provider Category:

Agency ▼

Provider Type:

Unlicensed Residential Habilitation Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

By July 1, 2014 those providing residential rehabilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program(adult) accreditation

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Respite ▼

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support ▼

Sub-Category 1:

09012 respite, in-home ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite Services are provided to individuals in their own home, or the home of relative,

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

Respite Services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Home Care Agency
Individual	Individual Respite Worker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Provider Type:

Provider Qualifications

License (specify):

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency Provider

Type: Home Care

Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

N/A

Other Standard (specify):

Agency:

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Respite Worker

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent/OLTL

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Case Management ▼

Alternate Service Title (if any):

Service Coordination

HCBS Taxonomy:

Category 1:

01 Case Management ▼

Sub-Category 1:

01010 case management ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Service Coordination identifies, coordinates and assists participants to gain access to needed waiver services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational and other services and supports.

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
-------------------	---------------------

Agency | Service Coordination Entity

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Service Coordination

Provider Category:

Agency ▼

Provider Type:

Service Coordination Entity

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Service Coordination Entities must:

- Comply with 55 PA Code 1101 and have a waiver provider agreement;

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Day Habilitation ▼

Alternate Service Title (if any):

Structured Day Habilitation Services

HCBS Taxonomy:

Category 1:

04 Day Services ▼

Sub-Category 1:

04020 day habilitation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver participants comprehensive day

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

Billing for Structured Day Habilitation:
Structured Day Habilitation Services do not include: 1:1 therapies (OT, PT, ST, Cognitive Rehabilitation Therapy, and

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Structured Day Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Structured Day Habilitation Services

Provider Category:

Provider Type:

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1:

03 Supported Employment ▼

Sub-Category 1:

03021 ongoing supported employment, individual ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Supported Employment Services are paid employment services for persons for whom competitive employment at or above the minimum wage is unlikely, and who because of their disability need intensive ongoing support to perform in a

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

When Supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency ▼

Provider Type:

Supported Employment Agency

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Every Two Years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service ▼

Service Title:

Home Health Services

HCBS Taxonomy:

Category 1:

05 Nursing ▼

Sub-Category 1:

05020 skilled nursing ▼

Category 2:

11 Other Health and Therapeutic Services ▼

Sub-Category 2:

11080 occupational therapy ▼

Category 3:

11 Other Health and Therapeutic Services ▼

Sub-Category 3:

11090 physical therapy ▼

Service Definition (Scope):

Category 4:**Sub-Category 4:**

11 Other Health and Therapeutic Services ▼

11100 speech, hearing, and language therapy ▼

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

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Speech Therapist (agency affiliated or individual)
Agency	Out-Patient or Community-Based Rehabilitation Agency
Individual	Physical Therapist or Assistant (agency affiliated or individual)
Individual	Occupational Therapist or Assistant (agency affiliated or individual)

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

Service Type: Extended State Plan Service

Service Name: Home Health Services

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications**License** (specify):

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

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

OLTL/PA Department of Health

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Services

Provider Category:

Individual ▼

Provider Type:

Speech Therapist (agency affiliated or individual)

Provider Qualifications

License (specify):

Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

PA Department of State Language and Hearing Examiner's Board

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Services

Provider Category:

Agency ▼

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications

License (specify):

Licensed by the PA Department of Health, per 28 PA Code

Certificate (specify):

Certification as required by per 42CFR Part 484
Certified by CARF as a Medical Rehabilitation Provider

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Services

Provider Category:

Individual ▾

Provider Type:

Physical Therapist or Assistant (agency affiliated or individual)

Provider Qualifications

License (*specify*):

Licensed under PA Department of State, per 49 PA Code Chapter 40, including 40.53 pertaining to delegation of duties and use of assistants (Physical Therapy Licensing Board)

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

PA Department of State Physical Therapy Licensing Board

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Services

Provider Category:

Individual ▾

Provider Type:

Occupational Therapist or Assistant (agency affiliated or individual)

Provider Qualifications

License (*specify*):

Licensed under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board)

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

PA Department of State Occupational Therapy and Education Licensing Board

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-directio

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

EFFECTIVE JANUARY 1, 2013, FINANCIAL MANAGEMENT SERVICES ARE PROVIDED AS AN ADMINISTRATIVE ACTIVITY.

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

EFFECTIVE JANUARY 1, 2013, FINANCIAL MANAGEMENT SERVICES ARE PROVIDED AS AN ADMINISTRATIVE ACTIVITY.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Government Fiscal/Employer Agent
Agency	Vendor Fiscal/Employer Agent

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency ▾

Provider Type:

Government Fiscal/Employer Agent

Provider Qualifications

License (specify):

Government Fiscal/Employer Agent

Certificate (specify):

Other Standard (specify):

Must meet all requirements of OLTL F/EA Financial Management Services Provider Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Upon initial enrollment
 Every two years thereafter

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency ▾

Provider Type:

Vendor Fiscal/Employer Agent

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Must meet all requirements of OLTL F/EA Financial Management Services Provider Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Upon initial enrollment
Every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Accessibility Adaptations, Equipment, Technology and Medical Supplies

HCBS Taxonomy:

Category 1:

▼

Sub-Category 1:

▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (*Scope*):

ACCESSIBILITY ADAPTATIONS, EQUIPMENT, TECHNOLOGY AND MEDICAL SUPPLIES IS NO LONGER A SERVICE IN THE OBRA WAIVER EFFECTIVE JULY 1, 2015. PLEASE SEE HOME ADAPTATIONS; ASSISTIVE

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

ACCESSIBILITY ADAPTATIONS, EQUIPMENT, TECHNOLOGY AND MEDICAL SUPPLIES IS NO LONGER A SERVICE IN THE OBRA WAIVER EFFECTIVE JULY 1, 2015. PLEASE SEE HOME ADAPTATIONS; ASSISTIVE

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Pharmacy
Agency	Durable Medical Equipment and Supply Company

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies

Provider Category:

Individual ▼

Provider Type:

Contractor

Provider Qualifications

License (specify):

Contractor's license for state of Pennsylvania, if required by trade

Certificate (specify):

Other Standard (specify):

Individuals who provide accessibility adaptations must:

- be 18 years of age or older

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDs, OLTL

Frequency of Verification:

At time of service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies

Provider Category:

Agency ▼

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet state regulations under 55 PA Code 1101 and 1121 regarding participation for pharmacists

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCD, OLTL

Frequency of Verification:

At time of service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies

Provider Category:

Agency ▼

Provider Type:

Durable Medical Equipment and Supply Company

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCD, OLTL

Frequency of Verification:

At time of service

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14032 supplies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the participant, as specified in the participant’s individual service plan (ISP)

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

Assistive Technology services may only be funded through the waiver when the services are not covered by the State Plan, EPSDT or a responsible third-party, such as Medicare or private insurance. Supports Coordinators must assure that

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Durable Medical Equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDs

Frequency of Verification:

Upon purchase

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency ▼

Provider Type:

Durable Medical Equipment

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDs or OLTL

Frequency of Verification:

OHCDs - Upon purchase
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:

04 Day Services ▼

Sub-Category 1:

04070 community integration ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Community Integration is a short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community.

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

Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Integration

Provider Category:

Agency ▼

Provider Type:

Community Integration Agency

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services ▼

Sub-Category 1:

16010 community transition services ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The service must be specified in the service plan as necessary

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

- Community Transition Services are furnished only to the extent that they are reasonable and necessary, as determined through the ISP development process; clearly identified in the service plan and the participant is unable to

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Transitional Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCD
OLTL

Frequency of Verification:

OHCD - Upon Purchase and Annually thereafter
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Adaptations

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications ▼

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Home Adaptations are physical adaptations to the private residence of the participant, as specified in the participant's individual service plan (ISP) and determined necessary in accordance with the participant's assessment, to ensure the

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

Home Adaptations may only be funded through the waiver when the services are not covered by the State Plan, EPDST or a responsible third-party, such as Medicare or private insurance. Supports Coordinators must assure that coverage of

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Adaptations

Provider Category:

Agency ▼

Provider Type:

Durable Medical Equipment

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDSD or OLTL

Frequency of Verification:

OHCDSD - At time of service
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Adaptations

Provider Category:

Individual ▼

Provider Type:

Contractor

Provider Qualifications

License (specify):

Contractor's license for the State of Pennsylvania or a state contiguous to Pennsylvania, if required by trade.

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDSD or OLTL

Frequency of Verification:

OHCDSD - At time of service
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation ▼

Sub-Category 1:

15010 non-medical transportation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Non-Medical Transportation services are offered in order to enable participants to gain access to waiver services as specified in the individualized service plan. This service is offered in addition to medical transportation services

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

Medical Assistance Transportation Program (MATP) services will be used for obtaining State Plan services. The participant's service plan must document the need for those Non-medical Transportation services that are not covered

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Driver
Agency	Licensed Transportation Agency, Public Transit Authority

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual ▼

Provider Type:

Individual Driver

Provider Qualifications

License (specify):

Valid Pennsylvania driver's license appropriate to the vehicle

Certificate (specify):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used to provide the Transportation service.

Other Standard (specify):

Drivers must meet the following:
• 18 years of age;

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDS
OLTL

Frequency of Verification:

OHCDS verifies provider qualifications prior to service approval; annually thereafter
OLTL monitors the OHCDS every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency ▼

Provider Type:

Licensed Transportation Agency, Public Transit Authority

Provider Qualifications

License (specify):

Licensed by the P.U.C and/or be a Public Transit Authority, a Community Transportation Provider or Community Transportation Subcontractor

Certificate (specify):

N/A

Other Standard (specify):

Agencies must:
• Meet PA Vehicle Code (Title 75);

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDS
OLTL

Frequency of Verification:

OHCDS verifies provider qualifications prior to service approval; annually thereafter
OLTL monitors the OHCDS every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications ▼

Sub-Category 1:

14010 personal emergency response system (PERS) ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

PERS is an electronic device which enables waiver participants to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors of Personal Emergency Response Systems
Agency	Durable Medical Equipment and Supply Company
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency ▼

Provider Type:

Vendors of Personal Emergency Response Systems

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/OHCDS

Frequency of Verification:

OHCDS - Upon Installation and Annually thereafter

OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency ▼

Provider Type:

Durable Medical Equipment and Supply Company

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/OHCDS

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/OHCDS

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications ▼

Sub-Category 1:

14032 supplies ▼

Category 2:

14 Equipment, Technology, and Modifications ▼

Sub-Category 2:

14031 equipment and technology ▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant's disability. These services or items are necessary to ensure health,

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

Specialized Medical Equipment and Supplies may only be funded through the waiver when the services are not covered by the State Plan, EPSDT or a responsible third-party, such as Medicare or private insurance. Service Coordinators must

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency ▼

Provider Type:

Durable Medical Equipment

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency ▼

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

Permit to conduct a pharmacy, under 49 PA Code, Part I, Subpart A. Chapter 27

Certificate (specify):

Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of State

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Therapeutic and Counseling Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

11 Other Health and Therapeutic Services ▼

11040 nutrition consultation ▼

Category 2:

Sub-Category 2:

11 Other Health and Therapeutic Services ▼

11120 cognitive rehabilitative therapy ▼

Category 3:

Sub-Category 3:

10 Other Mental Health and Behavioral Services ▼

10040 behavior support ▼

Category 4:

Sub-Category 4:

10 Other Mental Health and Behavioral Services ▼

10060 counseling ▼

Service Definition (*Scope*):

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community.

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

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

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychologist
Individual	Registered Dietitian or Certified Nutrition Specialist
Agency	Home Health Agency
Individual	Cognitive Rehabilitation Therapist
Individual	Licensed Professional Counselor
Individual	Behavioral Specialist
Individual	Licensed Social Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual Provider

Type: Licensed

Psychologist

Provider Qualifications

License (*specify*):

Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41

Certificate (*specify*):

N/A

Other Standard (*specify*):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA State Board of Psychology Professional Psychologists

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual ▼

Provider Type:

Registered Dietitian or Certified Nutrition Specialist

Provider Qualifications

License (*specify*):

Licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21, subchapter G

Certificate (*specify*):

N/A

Other Standard (*specify*):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of State Board of Dietitian-Nutritionists

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

Agency:

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual ▼

Provider Type:

Cognitive Rehabilitation Therapist

Provider Qualifications

License (*specify*):

Licensure specific to discipline

Certificate (*specify*):

Certified Brain Injury Specialist (CBIS); OR Certification by the Society for Cognitive Rehabilitation. Certification or registration specific to discipline

Other Standard (*specify*):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual ▼

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48, and 49

Certificate *(specify):*

N/A

Other Standard *(specify):*

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual Provider

Type: Behavioral

Specialist

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic and Counseling Services

Provider Category:

Individual Provider

Type: Licensed Social

Worker

Provider Qualifications

License (specify):

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48, and 49

Certificate (specify):

N/A

Other Standard (specify):

- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

Frequency of Verification:

At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

▼	▼
---	---

Vehicle Modifications are modifications or alterations to an automobile or van that is the participant’s means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are modifications

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

A vehicle is required to have passed all applicable State standards.
 This service does not include, but requires, an independent evaluation. Depending on the type of modification, and in

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modifications Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency ▼

Provider Type:

Vehicle Modifications Contractor

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Quality Assurance Program (QAP) Accreditation by the National Mobility Equipment Dealers Association (NMEDA).

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDSD or OLTL

Frequency of Verification:

OHCDSD - At time of service
 OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal history checks are required for all support service workers and must be conducted in accordance with 55 PA Code, Chapter 52, Sections 52.19 and 52.20. Individuals choosing to self-direct their services have the right to employ a

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

- Ⓒ Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Facility Type	.
Personal Care Home	

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

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response System	<input type="checkbox"/>
Residential Habilitation Services	<input checked="" type="checkbox"/>
Home Health Services	<input type="checkbox"/>
Adult Daily Living	<input type="checkbox"/>
Personal Assistance Services	<input type="checkbox"/>
Community Integration	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Service Coordination	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Home Adaptations	<input type="checkbox"/>
Education	<input type="checkbox"/>
Therapeutic and Counseling Services	<input type="checkbox"/>
Structured Day Habilitation Services	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Accessibility Adaptations, Equipment, Technology and Medical Supplies	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>

Facility Capacity Limit:

8

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed

in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Family members can provide Personal Assistance Services; however, the following exclusions apply:

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

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

All willing and qualified providers have the opportunity to enroll as waiver providers at any time. OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Copies of the

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

QP-1: Number and Percent of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision
Numerator: Number of

newly enrolled providers who meet required licensure and initial QP standards prior to service provision Denominator: Number of newly enrolled provider applications

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

QP-2: Number and percent of providers continuing to meet applicable licensure/certification,

regulatory and applicable waiver standards following initial enrollment Numerator: Number of providers who continue to meet required licensure and initial QP standards Denominator: Number of providers reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

QP-5: Number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision
Numerator: Number of newly enrolled providers who meet required licensure and initial QP standards prior to service provision
Denominator: Number of newly enrolled provider applications

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>

Performance Measure:

QP-6: Number and percent of non-licensed/non-certified providers who continue to meet waiver provider qualifications
Numerator: Total number of non-licensed/non-certified providers continuing to meet required licensure and initial QP standards
Denominator: Number of non-licensed/non-certified providers reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:

QP-7: Number and percent of providers meeting provider training requirements
Numerator: Number of providers who meet training requirements
Denominator: Total number of providers reviewed

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95% + - 5%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

Other
Specify:

--	--	--

Data Aggregation and Analysis:

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

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

The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised

b. Methods for Remediation/Fixing Individual Problems

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

Subassurance a.i.a - Before a provider is enrolled as a qualified waiver provider, it must provide written documentation to the State Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No**
- Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Please see Module 1, Attachment #2 HCBS Settings Waiver Transition Plan. At the time of submission OLTL is gathering relevant information needed for compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker

Specify qualifications:

- Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Individual Service Plan (ISP) development process is a collaborative process between the participant and Service Coordinator that includes people chosen by the participant, provides necessary information and support to ensure that the

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

The 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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The service plan assessment process includes the identification of potential risks to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Service Coordination entities are required to be conflict free as defined in 55 PA Code, Chapter 52.28. A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

SP-1: Number and percent of waiver participants with Individual Service Plan ISPs adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment
Numerator: Number of waiver participants with adequate and appropriate Individual Service Plans (ISPs)
Denominator: Total number of service plan reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: retrospective service plan review database	

Data Aggregation and Analysis:

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

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

Performance Measure:

SP-2: Number and percent of waiver participant satisfaction survey respondents who reported unmet needs

Numerator: Number of waiver participants who reported unmet needs

Denominator: Total number of participants responding to the survey

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95% + - 5%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Two times per year"/>	

Data Aggregation and Analysis:

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

Specify:	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Two times a year

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

SP-3: Number and percent of Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date
Numerator: Number of Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date
Denominator: Total number of Service plans reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

SP-4: Number and percent of waiver participants who are received authorized services in the type, scope, amount, frequency and duration specified in the Individual Service Plan (ISPs)

Numerator: Number of waiver participants who are receiving services specified in the Individual Service Plan (ISP) Denominator: Total number of service plan reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: retrospective service plan database	

Data Aggregation and Analysis:

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

Performance Measure:

SP-5: Number and percent of waiver providers who delivered services in the type, scope, amount, frequency, and duration specified in the Individual Service Plan (ISP). Numerator: Number of waiver providers who delivered services in the type, scope, amount, frequency, and duration specified in the Individual Service Plan Denominator: Total number of providers reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

SP-6: Number and percent of waiver participant satisfaction survey respondents reporting the receipt of all services in Individual Service Plan (ISP)
Numerator: Total number of participants reporting receipt of all services in ISP
Denominator: Total number of participants responding to the survey

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Two times per year	

Data Aggregation and Analysis:

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

Performance Measure:

SP-7: Number and percent of complaints received regarding non-receipt of services

Numerator: Number of complaints received regarding non-receipt of services **Denominator: Total number of complaints**

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

SP-8: Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator: Number of waiver participants with documented evidence of opportunities Denominator: Total number of service plans reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: retrospective service plan review	

Data Aggregation and Analysis:

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

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

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

At the Service Coordination Agency, the SC supervisor reviews the ISP for completeness and appropriateness prior to submitting the ISP to the Bureau of Individual Support (BIS) for approval. The supervisor is the first step in the

b. Methods for Remediation/Fixing Individual Problems

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

When ISPs are reviewed for compliance and non-compliance is noted, BQPM issues a Quality Improvement Plan (QIP) to the BPO to address the non-compliance. The BPO submits a plan to correct the non-compliance to BQPM within the

- ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

- No**
 Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

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

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

Indicate whether Independence Plus designation is requested (select one):

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Self-Directed Opportunities Available within the OBRA Waiver:
All participants in the OBRA waiver have the right to make decisions about and self-direct their own waiver services and may

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct**

their services.

- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative freely chosen by an adult participant or for any individual who is unable to:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided to participants across the Commonwealth by one qualified Fiscal Employer Agent, which was selected through a competitive procurement process (RFA).

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

••The statewide F/EA receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. The monthly administrative fee was established through the competitive procurement process.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
 Collect and process timesheets of support workers
 Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
 Other

Specify:

•• Enroll participants in FMS and apply for and receive approval from the IRS to act as a an agent on behalf of the participant;

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
 Track and report participant funds, disbursements and the balance of participant funds
 Process and pay invoices for goods and services approved in the service plan
 Provide participant with periodic reports of expenditures and the status of the participant-directed budget
 Other services and supports

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The statewide F/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System	<input type="checkbox"/>
Residential Habilitation Services	<input type="checkbox"/>
Home Health Services	<input type="checkbox"/>
Adult Daily Living	<input type="checkbox"/>
Personal Assistance Services	<input type="checkbox"/>
Community Integration	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Service Coordination	<input checked="" type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>

Respite	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Home Adaptations	<input type="checkbox"/>
Education	<input type="checkbox"/>
Therapeutic and Counseling Services	<input type="checkbox"/>
Structured Day Habilitation Services	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Accessibility Adaptations, Equipment, Technology and Medical Supplies	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities to provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants have the option to transition from the participant direction to the provider managed service delivery model at any point during their waiver enrollment. When a participant voluntarily chooses to terminate participant direction, they will

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority			
	Number of Participants	Number of Participants			
Year 1	600				
Year 2	600				
Year 3	600				
Year 4	600				
Year 5	600				

Appendix E: Participant Direction of Services

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

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

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

To ensure all participants make informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services. The FMS agency secures and pays for the

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply
 Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply
 Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

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

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

OLTL operates a Customer Service line, also known as the OLTL HelpLine. The OLTL HelpLine (1-800-757-5042) is located in the Bureau of Participant Operations and is staffed by OLTL personnel during normal business hours. Participants,

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
 No. This Appendix does not apply (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office of Long-Term Living has initiated a comprehensive incident reporting and management process. Critical events are referred to as critical incidents and defined as an event that jeopardizes the participant's health and welfare. Two OLTL

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At time of enrollment, the IEB informs participants of the incident management process. This information is provided through the participant information materials developed by OLTL. These materials include how to recognize and report abuse, neglect

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

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

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OLTL is responsible for providing oversight of Critical Incidents and events. OLTL staff from BQPM and BPO work together to address critical incidents. BQPM staff reviews reports generated in EIM to track and trend critical incidents. BPO staff work

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of restraints

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

At time of enrollment, the IEB informs participants of the prohibition on the use of restraints, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one):*

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

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

At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

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

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

At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

OLTL uses the 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

Appendix G: Participant Safeguards

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

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.** Select one:

- Not applicable. (do not complete the remaining items)
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration by Licensed Residential Habilitation Providers:
Personal Care Home regulations, 55 PA Code, Chapter 2600, apply when participants receive Residential Habilitation

iii. **Medication Error Reporting.** Select one of the following:

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization

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

Providers record medication errors which include: failure to administer a medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer a medication at the

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

Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

OLTL monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3-b-i, direct monitoring occurs through annual DHS licensing reviews of licensed

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

HW-1: Number and percent of unexplained or suspicious deaths for which review/investigation resulted in findings where appropriate follow-up or steps were taken Numerator: Unexplained or suspicious deaths for which review/investigation resulted in findings where appropriate follow-up or steps were taken Denominator: Total number of unexplained or suspicious deaths

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

HW-2: Number and percent of substantiated cases of abuse, neglect, or exploitation where recommended actions in the protect health and welfare were implemented
Numerator: Number of substantiated cases of Abuse,neglect, or exploitation where recommended actions to protect health and welfare were implemented
Denominator: Total number of substantiated cases of abuse, neglect, or exploitation

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-3: Number and percent of Urgent complaints with investigation initiated within the required timeframe
Numerator: Number and percent of urgent complaints with investigation initiated within the required timeframe
Denominator: Total number of urgent complaints

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

HW-4: Number and percent of Non-Urgent complaints with investigation initiated within the required timeframe
Numerator: Number of non-urgent complaints with investigation initiated within the required timeframe
Denominator: Total number of non-urgent complaints

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

HW-5: Number and percent of complaints, investigated/closed within required timeframe

Numerator: Number of complaints, investigated/closed within required timeframe

Denominator: Total number of complaints

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

HW-6: Number and percent of waiver participants, responding to the satisfaction survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Numerator: Number and of waiver participants, responding to the satisfaction survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Denominator: Total number of participants responding to the survey

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Two times per year	

Data Aggregation and Analysis:

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

Other

Specify:

Two times per year

Performance Measure:

HW-7: Number and percent of waiver participants who were informed of the reporting process for abuse, neglect and exploitation
Numerator: Number of waiver participants who were informed of the reporting process for abuse, neglect, and exploitation
Denominator: Total number of service plans reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% + - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: service plan retrospective database	

Data Aggregation and Analysis:

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

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

Performance Measure:

HW-8: Number and percent of waiver participants with more than three reported incidents within the past 365 calendar days
Numerator: Number and percent of waiver participants with four or more reported incidents within the past 365 calendar days
Denominator: Number of waiver participants with reported critical incidents

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

HW-9: Number and percent of critical incidents reported within the required timeframe

Numerator: Number of critical incidents reported within the required timeframe Denominator: Number of critical incidents reported

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>

Performance Measure:

HW-10: Number and percent of reportable incidents investigated within required timeframe

Numerator: Number of reportable critical incidents investigated within required timeframe

Denominator: Total number of reportable critical incidents

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

HW-11: Number and percent of critical incidents requiring investigation where the state adhered to the follow-up methods as specified in the approved waiver
Numerator: Number of critical incidents requiring investigation where the state adhered to the follow-up methods as specified in the approved waiver
Denominator: Total number of critical incidents requiring investigation

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

HW-12: Number and percent of incidents where unauthorized uses of restrictive interventions were appropriately reported
Numerator: Number of incidents where unauthorized uses of restrictive interventions were appropriately reported
Denominator: Total number of incidents with unauthorized uses of restrictive interventions

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>

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

Performance Measures

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

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

Performance Measure:

HW-13: Number and percent of waiver participants receiving age-appropriate preventative health care
Numerator: Number of waiver participants receiving age-appropriate preventative health care
Denominator: Total number of waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

PROMISE paid claims report, enrolled waiver participants

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

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

Data Aggregation and Analysis:

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

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

Statistical reports on 100% of reported critical incidents and complaints are generated from the state's Enterprise Incident Management (EIM) system and these reports are reviewed monthly by the Bureau of Quality & Provider

b. Methods for Remediation/Fixing Individual Problems

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

When it is discovered that an incident was not acted upon in accordance with waiver standards (not reported, not investigated within the required timeframe, etc.) OLTL staff that discovered the issues immediately directs the provider

- ii. **Remediation Data Aggregation**

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):

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

c. Timelines

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

- No**
- Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

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

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

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

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

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

The Bureau of Quality and Provider Management (BQPM) in the Office of Long Term Living (OLTL) is responsible for developing and maintaining the Quality Improvement Strategy (QIS).

ii. System Improvement Activities

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

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Summarized below are the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each assurance.

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

The process to continuously assess the effectiveness of this QIS and revise as necessary is as follows:

- Two years after the waiver renewal date, a Quality Management Meeting will be held with the sole purpose of

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The 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:

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

FA-1: Number and percent of claims paid within in accordance with approved waiver

Numerator: Number of claims paid within in accordance with approved waiver Denominator:

Total number of claims paid

Data Source (Select one):

Other

If 'Other' is selected, specify:

PROMISE paid claims

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

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

Data Aggregation and Analysis:

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

Performance Measure:

FA-2: Number and percent of provider's submitting accurate claims for services authorized by the waiver and being paid for those services
Numerator: Total number of providers submitting accurate claims for services authorized
Denominator: Total number of providers reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

FA-4: Number and percent of provider payment rates that are consistent with rate methodology approved in the approved waiver application or subsequent amendment
Numerator: Number and percent of provider payments rates are consistent with rate methodology approved in the approved waiver application or subsequent amendmen
Denominator: Total number of provider payments using the appropriate rate

Data Source (Select one):

Other

If 'Other' is selected, specify:

Claims data, documentation from State rate setting division

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

Data Aggregation and Analysis:

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

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

A "Paid Claims Report" has been developed that runs every paid claim against a valid list of procedure codes. 100% of all paid claims are run through the query which is written to list any claims that paid with an incorrect code. If any

b. Methods for Remediation/Fixing Individual Problems

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

If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/Bureau of Quality & Provider Management initiates steps to recoup the overpayment.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

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

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Appendix I: Financial Accountability

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

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

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

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

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

OLTL ensures that the individual was eligible for Medicaid waiver payment on the date of service, the service was included in the participant's approved service plan, and the services were provided through the use of the following strategies and tools:

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

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

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a. Entities eligible for designation as OHCDS for services within this waiver are service coordination entities, all of which render at least one Medicaid service directly (Service Coordination) utilizing its own employees.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**

Check each that applies:

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

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

In 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.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
 - ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
 - iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
 - iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	46505.94	7661.00	54166.94	251536.00	10038.00	261574.00	207407.06
2	43546.27	7814.00	51360.27	251536.00	10239.00	261775.00	210414.73
3	43240.18	7970.00	51210.18	251536.00	10444.00	261980.00	210769.82
4	43240.18	8130.00	51370.18	251536.00	10653.00	262189.00	210818.82
5	43172.28	8292.00	51464.28	251536.00	10866.00	262402.00	210937.72

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	1694		1694
Year 2	1694		1694
Year 3	1694		1694
Year 4	1694		1694
Year 5	1694		1694

Appendix J: Cost Neutrality Demonstration

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

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Based on actual history of utilization and establishing a percentage each service is utilized compared to all services. The number of participants is projected from history and average participants entering the waiver and average

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is obtained the same way as described under Factor D. The entire database of waiver participants is available to identify each participant's non-waiver MA costs, including the deduction of Medicare Part D drug costs. Payments

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is

as follows:

Factor G is based on current ICF/ORC rates, and does not reflect any rate adjustments over the five year period.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on actual claims history, which includes the deduction of Medicare drug costs. Factor G' reflects a two percent (2%) increase each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Daily Living	
Education	
Personal Assistance Services	
Prevocational Services	
Residential Habilitation Services	
Respite	
Service Coordination	
Structured Day Habilitation Services	
Supported Employment	
Home Health Services	
Financial Management Services	
Accessibility Adaptations, Equipment, Technology and Medical Supplies	
Assistive Technology	
Community Integration	
Community Transition Services	
Home Adaptations	
Non-Medical Transportation	
Personal Emergency Response System	
Specialized Medical Equipment and Supplies	
Therapeutic and Counseling Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						368562.55
Enhanced Day	Day <input type="text"/>	<input type="text" value="5"/>	<input type="text" value="100.00"/>	<input type="text" value="71.74"/>	35870.00	

Basic Day	Day	35	149.00	59.73	311491.95	
Basic Half Day	Half Day	5	142.00	29.86	21200.60	
Enhanced Half Day	Half Day	0	0.00	8.35	0.00	
Education Total:						336751.80
Education	15 Min	33	370.00	27.58	336751.80	
Personal Assistance Services Total:						48635647.98
Agency	15 Min	719	6279.00	4.58	20676872.58	
Participant-Directed	15 Min	1014	7747.00	3.54	27808321.32	
CSLA	15 Min	18	1756.00	4.76	150454.08	
Prevocational Services Total:						1234083.84
Prevocational Services	15 Min	66	2816.00	6.64	1234083.84	
Residential Habilitation Services Total:						3699978.00
Residential Habilitation Licensed	Per Diem	33	300.00	247.67	2451933.00	
Residential Habilitation Unlicensed	Per Diem	15	300.00	264.15	1188675.00	
Residential Habilitation Enhanced 1:1	Hour	4	500.00	19.79	39580.00	
Residential Habilitation Enhanced 2:1	Hour	1	500.00	39.58	19790.00	
Respite Total:						3632571.06
Agency	15 Min	213	1529.00	4.58	1491600.66	
Participant-Directed	15 Min	360	1563.00	3.54	1991887.20	
Respite	Per Diem	70	12.00	177.48	149083.20	
Service Coordination Total:						6520216.50
Service Coordination	Weekly	1635	45.00	88.62	6520216.50	
Structured Day Habilitation Services Total:						2339815.00
Structured Day Habilitation	Hour	48	1375.00	34.56	2280960.00	
Structured Day Habilitation - Enhanced 1:1	Hour	4	500.00	19.62	39240.00	
Structured Day Habilitation - Enhanced 2:1	Hour	1	500.00	39.23	19615.00	
Supported Employment Total:						351800.20

Supported Employment	Hour	38	215.00	43.06	351800.20	
Home Health Services Total:						3260790.22
Occupational Therapy	15 Min	34	192.00	19.32	126120.96	
Speech Therapy	15 Min	34	217.00	19.71	145420.38	
Physical Therapy	15 Min	34	244.00	18.33	152065.68	
Nursing - RN	15 Min	20	6074.00	15.02	1824629.60	
Nursing - LPN	15 Min	15	6074.00	10.00	911100.00	
Occupational Therapy Assistant	15 Min	20	192.00	13.14	50457.60	
Physical Therapy Assistant	15 Min	20	244.00	10.45	50996.00	
Financial Management Services Total:						863285.00
Financial Management Services	Month	1014	10.00	85.00	861900.00	
Financial Management Services - Start Up	Onr Time	5	1.00	277.00	1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						1293628.00
Adaptation	Purchase	188	1.00	5035.00	946580.00	
Equipment	Purchase	188	1.00	1846.00	347048.00	
Assistive Technology Total:						0.00
Assistive Technology	Purchase	0	0.00	1078.90	0.00	
Community Integration Total:						4915558.40
Community Integration	15 Min	380	1984.00	6.52	4915558.40	
Community Transition Services Total:						20000.00
Community Transition Services	Purchase	5	1.00	4000.00	20000.00	
Home Adaptations Total:						0.00
Home Adaptations	Adaptation	0	0.00	6954.03	0.00	
Non-Medical Transportation Total:						927010.00
Non-Medical Transportation	Trip	779	119.00	10.00	927010.00	
Personal Emergency Response System						315900.00

Total:						
Personal Emergency Response System	Month	702	10.00	45.00	315900.00	
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	Purchase	0	0.00	1001.04	0.00	
Therapeutic and Counseling Services Total:						65467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	13.64	17240.96	
Counseling	15 Min	9	147.00	11.43	15121.89	
Nutritional Counseling	15 Min	8	147.00	13.30	15640.80	
Behavior Therapy	15 Min	8	147.00	14.85	17463.60	
Vehicle Modifications Total:						0.00
Vehicle Modifications	Adaptation	0	0.00	1078.90	0.00	
GRAND TOTAL:					78781065.80	
Total Estimated Unduplicated Participants:					1694	
Factor D (Divide total by number of participants):					46505.94	
Average Length of Stay on the Waiver:						300

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						368562.55
Enhanced Day	Day	5	100.00	71.74	35870.00	
Basic Day	Day	35	149.00	59.73	311491.95	
Basic Half Day	Half Day	5	142.00	29.86	21200.60	
Enhanced Half Day	Half Day	0	0.00	8.35	0.00	
Education Total:						0.00
Education	15 Min	0	370.00	27.58	0.00	
Personal Assistance						

						48635647.98
Agency	15 Min	719	6279.00	4.58	20676872.58	
Participant-Directed	15 Min	1014	7747.00	3.54	27808321.32	
CSLA	15 Min	18	1756.00	4.76	150454.08	
Prevocational Services Total:						1234083.84
Prevocational Services	15 Min	66	2816.00	6.64	1234083.84	
Residential Habilitation Services Total:						3699978.00
Residential Habilitation Licensed	Per Diem	33	300.00	247.67	2451933.00	
Residential Habilitation Unlicensed	Per Diem	15	300.00	264.15	1188675.00	
Residential Habilitation Enhanced 1:1	Hour	4	500.00	19.79	39580.00	
Residential Habilitation Enhanced 2:1	Hour	1	500.00	39.58	19790.00	
Respite Total:						3483487.86
Agency	15 Min	213	1529.00	4.58	1491600.66	
Participant-Directed	15 Min	360	1563.00	3.54	1991887.20	
Respite	Per Diem	0	12.00	177.48	0.00	
Service Coordination Total:						2337134.40
Service Coordination	15 Min	1635	96.00	14.89	2337134.40	
Structured Day Habilitation Services Total:						2339815.00
Structured Day Habilitation	Hour	48	1375.00	34.56	2280960.00	
Structured Day Habilitation - Enhanced 1:1	Hour	4	500.00	19.62	39240.00	
Structured Day Habilitation - Enhanced 2:1	Hour	1	500.00	39.23	19615.00	
Supported Employment Total:						351800.20
Supported Employment	Hour	38	215.00	43.06	351800.20	
Home Health Services Total:						3260790.22
Occupational Therapy	15 Min	34	192.00	19.32	126120.96	
Speech Therapy	15 Min	34	217.00	19.71	145420.38	
Physical Therapy	15 Min	34	244.00	18.33	152065.68	

Nursing - RN	15 Min	20	6074.00	15.02	1824629.60	
Nursing - LPN	15 Min	15	6074.00	10.00	911100.00	
Occupational Therapy Assistant	15 Min	20	192.00	13.14	50457.60	
Physical Therapy Assistant	15 Min	20	244.00	10.45	50996.00	
Financial Management Services Total:						518525.00
Financial Management Services	Month	1014	6.00	85.00	517140.00	
Financial Management Services - Start Up	Onr Time	5	1.00	277.00	1385.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						1293628.00
Adaptation	Purchase	188	1.00	5035.00	946580.00	
Equipment	Purchase	188	1.00	1846.00	347048.00	
Assistive Technology Total:						0.00
Assistive Technology	Purchase	0	0.00	1078.90	0.00	
Community Integration Total:						4915558.40
Community Integration	15 Min	380	1984.00	6.52	4915558.40	
Community Transition Services Total:						20000.00
Community Transition Services	Purchase	5	1.00	4000.00	20000.00	
Home Adaptations Total:						0.00
Home Adaptations	Adaptation	0	0.00	6954.03	0.00	
Non-Medical Transportation Total:						927010.00
Non-Medical Transportation	Trip	779	119.00	10.00	927010.00	
Personal Emergency Response System Total:						315900.00
Personal Emergency Response System	Month	702	10.00	45.00	315900.00	
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	Purchase	0	0.00	1001.01	0.00	
Therapeutic and						

Counseling Services Total:						65467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	13.64	17240.96	
Counseling	15 Min	9	147.00	11.43	15121.89	
Nutritional Counseling	15 Min	8	147.00	13.30	15640.80	
Behavior Therapy	15 Min	8	147.00	14.85	17463.60	
Vehicle Modifications Total:						0.00
Vehicle Modifications	Adaptation	0	0.00	1078.90	0.00	
GRAND TOTAL:						73767388.70
Total Estimated Unduplicated Participants:						1694
Factor D (Divide total by number of participants):						43546.27
Average Length of Stay on the Waiver:						300

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						368562.55
Enhanced Day	Day	5	100.00	71.74	35870.00	
Basic Day	Day	35	149.00	59.73	311491.95	
Basic Half Day	Half Day	5	142.00	29.86	21200.60	
Enhanced Half Day	Half Day	0	0.00	8.35	0.00	
Education Total:						0.00
Education	15 Min	0	370.00	27.58	0.00	
Personal Assistance Services Total:						48635647.98
Agency	15 Min	719	6279.00	4.58	20676872.58	
Participant-Directed	15 Min	1014	7747.00	3.54	27808321.32	
CSLA	15 Min	18	1756.00	4.76	150454.08	
Prevocational Services Total:						1234083.84

Prevocational Services	15 Min	66	2816.00	6.64	1234083.84	
Residential Habilitation Services Total:						3699978.00
Residential Habilitation Licensed	Per Diem	33	300.00	247.67	2451933.00	
Residential Habilitation Unlicensed	Per Diem	15	300.00	264.15	1188675.00	
Residential Habilitation Enhanced 1:1	Hour	4	500.00	19.79	39580.00	
Residential Habilitation Enhanced 2:1	Hour	1	500.00	39.58	19790.00	
Respite Total:						3483487.86
Agency	15 Min	213	1529.00	4.58	1491600.66	
Participant-Directed	15 Min	360	1563.00	3.54	1991887.20	
Respite	Per Diem	0	12.00	177.48	0.00	
Service Coordination Total:						2337134.40
Service Coordination	15 Min	1635	96.00	14.89	2337134.40	
Structured Day Habilitation Services Total:						2339815.00
Structured Day Habilitation	Hour	48	1375.00	34.56	2280960.00	
Structured Day Habilitation - Enhanced 1:1	Hour	4	500.00	19.62	39240.00	
Structured Day Habilitation - Enhanced 2:1	Hour	1	500.00	39.23	19615.00	
Supported Employment Total:						351800.20
Supported Employment	Hour	38	215.00	43.06	351800.20	
Home Health Services Total:						3260790.22
Occupational Therapy	15 Min	34	192.00	19.32	126120.96	
Speech Therapy	15 Min	34	217.00	19.71	145420.38	
Physical Therapy	15 Min	34	244.00	18.33	152065.68	
Nursing - RN	15 Min	20	6074.00	15.02	1824629.60	
Nursing - LPN	15 Min	15	6074.00	10.00	911100.00	
Occupational Therapy Assistant	15 Min	20	192.00	13.14	50457.60	
Physical Therapy Assistant	15 Min	20	244.00	10.45	50996.00	
Financial						

Management Services Total:						0.00
Financial Management Services	Month	0	10.00	85.00	0.00	
Financial Management Services - Start Up	Onr Time	0	1.00	277.00	0.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						1293628.00
Adaptation	Purchase	188	1.00	5035.00	946580.00	
Equipment	Purchase	188	1.00	1846.00	347048.00	
Assistive Technology Total:						0.00
Assistive Technology	Purchase	0	0.00	1078.90	0.00	
Community Integration Total:						4915558.40
Community Integration	15 Min	380	1984.00	6.52	4915558.40	
Community Transition Services Total:						20000.00
Community Transition Services	Purchase	5	1.00	4000.00	20000.00	
Home Adaptations Total:						0.00
Home Adaptations	Adaptation	0	0.00	6954.03	0.00	
Non-Medical Transportation Total:						927010.00
Non-Medical Transportation	Trip	779	119.00	10.00	927010.00	
Personal Emergency Response System Total:						315900.00
Personal Emergency Response System	Month	702	10.00	45.00	315900.00	
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	Purchase	0	0.00	1001.04	0.00	
Therapeutic and Counseling Services Total:						65467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	13.64	17240.96	
Counseling	15 Min	9	147.00	11.43	15121.89	
Nutritional Counseling	15 Min	8	147.00	13.30	15640.80	
Behavior Therapy	15 Min	8	147.00	14.85	17463.60	
Vehicle						

Modifications Total:						0.00
Vehicle Modifications	Adaptation	0	0.00	1078.90	0.00	
GRAND TOTAL:						73248863.70
Total Estimated Unduplicated Participants:						1694
Factor D (Divide total by number of participants):						43240.18
Average Length of Stay on the Waiver:						300

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						368562.55
Enhanced Day	Day	5	100.00	71.74	35870.00	
Basic Day	Day	35	149.00	59.73	311491.95	
Basic Half Day	Half Day	5	142.00	29.86	21200.60	
Enhanced Half Day	Half Day	0	0.00	8.35	0.00	
Education Total:						0.00
Education	15 Min	0	370.00	27.58	0.00	
Personal Assistance Services Total:						48635647.98
Agency	15 Min	719	6279.00	4.58	20676872.58	
Participant-Directed	15 Min	1014	7747.00	3.54	27808321.32	
CSLA	15 Min	18	1756.00	4.76	150454.08	
Prevocational Services Total:						1234083.84
Prevocational Services	15 Min	66	2816.00	6.64	1234083.84	
Residential Habilitation Services Total:						3699978.00
Residential Habilitation Licensed	Per Diem	33	300.00	247.67	2451933.00	
Residential Habilitation Unlicensed	Per Diem	15	300.00	264.15	1188675.00	
Residential Habilitation Enhanced 1:1	Hour	4	500.00	19.79	39580.00	

Residential Habilitation Enhanced 2:1	Hour	1	500.00	39.58	19790.00	
Respite Total:						3483487.86
Agency	15 Min	213	1529.00	4.58	1491600.66	
Participant-Directed	15 Min	360	1563.00	3.54	1991887.20	
Respite	Per Diem	0	12.00	177.48	0.00	
Service Coordination Total:						2337134.40
Service Coordination	15 Min	1635	96.00	14.89	2337134.40	
Structured Day Habilitation Services Total:						2339815.00
Structured Day Habilitation	Hour	48	1375.00	34.56	2280960.00	
Structured Day Habilitation - Enhanced 1:1	Hour	4	500.00	19.62	39240.00	
Structured Day Habilitation - Enhanced 2:1	Hour	1	500.00	39.23	19615.00	
Supported Employment Total:						351800.20
Supported Employment	Hour	38	215.00	43.06	351800.20	
Home Health Services Total:						3260790.22
Occupational Therapy	15 Min	34	192.00	19.32	126120.96	
Speech Therapy	15 Min	34	217.00	19.71	145420.38	
Physical Therapy	15 Min	34	244.00	18.33	152065.68	
Nursing - RN	15 Min	20	6074.00	15.02	1824629.60	
Nursing - LPN	15 Min	15	6074.00	10.00	911100.00	
Occupational Therapy Assistant	15 Min	20	192.00	13.14	50457.60	
Physical Therapy Assistant	15 Min	20	244.00	10.45	50996.00	
Financial Management Services Total:						0.00
Financial Management Services	Month	0	10.00	85.00	0.00	
Financial Management Services - Start Up	Onr Time	0	1.00	277.00	0.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						1293628.00

	Purchase	188	1.00	5035.00		
Equipment	Purchase	188	1.00	1846.00	347048.00	
Assistive Technology Total:						0.00
Assistive Technology	Purchase	0	0.00	1078.90	0.00	
Community Integration Total:						4915558.40
Community Integration	15 Min	380	1984.00	6.52	4915558.40	
Community Transition Services Total:						20000.00
Community Transition Services	Purchase	5	1.00	4000.00	20000.00	
Home Adaptations Total:						0.00
Home Adaptations	Adaptation	0	0.00	6954.03	0.00	
Non-Medical Transportation Total:						927010.00
Non-Medical Transportation	Trip	779	119.00	10.00	927010.00	
Personal Emergency Response System Total:						315900.00
Personal Emergency Response System	Month	702	10.00	45.00	315900.00	
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	Purchase	0	0.00	1001.04	0.00	
Therapeutic and Counseling Services Total:						65467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	13.64	17240.96	
Counseling	15 Min	9	147.00	11.43	15121.89	
Nutritional Counseling	15 Min	8	147.00	13.30	15640.80	
Behavior Therapy	15 Min	8	147.00	14.85	17463.60	
Vehicle Modifications Total:						0.00
Vehicle Modifications	Adaptation	0	0.00	1078.90	0.00	
GRAND TOTAL:					73248863.70	
Total Estimated Unduplicated Participants:					1694	
Factor D (Divide total by number of participants):					43240.18	
Average Length of Stay on the Waiver:					300	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						378562.55
Enhanced Day	Day	5	100.00	71.74	35870.00	
Basic Day	Day	35	149.00	59.73	311491.95	
Basic Half Day	Half Day	5	142.00	29.86	21200.60	
Enhanced Half Day	Half Day	10	100.00	10.00	10000.00	
Education Total:						0.00
Education	15 Min	0	370.00	27.58	0.00	
Personal Assistance Services Total:						48635647.98
Agency	15 Min	719	6279.00	4.58	20676872.58	
Participant-Directed	15 Min	1014	7747.00	3.54	27808321.32	
CSLA	15 Min	18	1756.00	4.76	150454.08	
Prevocational Services Total:						1234083.84
Prevocational Services	15 Min	66	2816.00	6.64	1234083.84	
Residential Habilitation Services Total:						3699978.00
Residential Habilitation Licensed	Per Diem	33	300.00	247.67	2451933.00	
Residential Habilitation Unlicensed	Per Diem	15	300.00	264.15	1188675.00	
Residential Habilitation Enhanced 1:1	Hour	4	500.00	19.79	39580.00	
Residential Habilitation Enhanced 2:1	Hour	1	500.00	39.58	19790.00	
Respite Total:						3483487.86
Agency	15 Min	213	1529.00	4.58	1491600.66	
Participant-Directed	15 Min	360	1563.00	3.54	1991887.20	
Respite	Per Diem	0	12.00	177.48	0.00	

Service Coordination Total:						2332846.08
Service Coordination	15 Min	1632	96.00	14.89	2332846.08	
Structured Day Habilitation Services Total:						2339815.00
Structured Day Habilitation	Hour	48	1375.00	34.56	2280960.00	
Structured Day Habilitation - Enhanced 1:1	Hour	4	500.00	19.62	39240.00	
Structured Day Habilitation - Enhanced 2:1	Hour	1	500.00	39.23	19615.00	
Supported Employment Total:						351800.20
Supported Employment	Hour	38	215.00	43.06	351800.20	
Home Health Services Total:						3217632.06
Occupational Therapy	15 Min	34	192.00	19.32	126120.96	
Speech Therapy	15 Min	34	217.00	19.71	145420.38	
Physical Therapy	15 Min	34	244.00	18.33	152065.68	
Nursing - RN	15 Min	20	6074.00	15.02	1824629.60	
Nursing - LPN	15 Min	15	6074.00	10.00	911100.00	
Occupational Therapy Assistant	15 Min	13	192.00	13.14	32797.44	
Physical Therapy Assistant	15 Min	10	244.00	10.45	25498.00	
Financial Management Services Total:						0.00
Financial Management Services	Month	0	10.00	85.00	0.00	
Financial Management Services - Start Up	Onr Time	0	1.00	277.00	0.00	
Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:						0.00
Adaptation	Purchase	0	0.00	5035.00	0.00	
Equipment	Purchase	0	0.00	1846.00	0.00	
Assistive Technology Total:						70000.00
Assistive Technology	Purchase	10	1.00	7000.00	70000.00	
Community Integration Total:						4915558.40
Community						

Integration	15 Min	380	1984.00	6.52	4915558.40	
Community Transition Services Total:						20000.00
Community Transition Services	Purchase	5	1.00	4000.00	20000.00	
Home Adaptations Total:						764212.30
Home Adaptations	Adaptation	106	1.00	7209.55	764212.30	
Non-Medical Transportation Total:						927010.00
Non-Medical Transportation	Trip	779	119.00	10.00	927010.00	
Personal Emergency Response System Total:						315900.00
Personal Emergency Response System	Month	702	10.00	45.00	315900.00	
Specialized Medical Equipment and Supplies Total:						311843.40
Specialized Medical Equipment and Supplies	Purchase	148	1.00	2107.05	311843.40	
Therapeutic and Counseling Services Total:						65467.25
Cognitive Rehabilitation Therapy	15 Min	8	158.00	13.64	17240.96	
Counseling	15 Min	9	147.00	11.43	15121.89	
Nutritional Counseling	15 Min	8	147.00	13.30	15640.80	
Behavior Therapy	15 Min	8	147.00	14.85	17463.60	
Vehicle Modifications Total:						70000.00
Vehicle Modifications	Adaptation	10	1.00	7000.00	70000.00	
GRAND TOTAL:					73133844.92	
Total Estimated Unduplicated Participants:					1694	
Factor D (Divide total by number of participants):					43172.28	
Average Length of Stay on the Waiver:						300