# 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:**
**Pennsylvania''s Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver)**

**C. Waiver Number:PA.0279**
**Original Base Waiver Number: PA.0279.**

**D. Amendment Number:PA.0279.R04.02**

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

07/01/15

**Approved Effective Date: 10/28/15**
**Approved Effective Date of Waiver being Amended: 07/01/13**

### 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 Aging Waiver.

Notable changes in each Appendix in this amendment include:
Appendix A – Waiver Administration and Operation
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix B – Participant Access and Eligibility
• Increases the number of unduplicated recipients for Waiver Years 3, 4 and 5 (SFY 2015-16, 2016-17 and 2017-18).
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix C – Participant Services
• Removes the exception process to allow Powers of Attorney to serve as paid caregivers for participants; adds an exclusion for Representative Payees to serve as paid caregivers.
• Removes the reference to "contracted staff" in the provider qualifications section of the Personal Assistance Services service definition.
• Removes the "Accessibility Adaptations, Equipment, Technology and Medical Supplies" service definition, and creates four new discreet service definitions – Home Adaptations, Vehicle Modifications, Assistive Technology and Specialized Medical Equipment and Supplies.
• Adds a half-day unit of service for Adult Daily Living – Enhanced.
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix D – Participant-Centered Planning and Service Delivery
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix G – Participant Safeguards
• Revises the critical incident reporting and management process to reflect current practice and demonstrate that necessary processes are in place to protect the health and welfare of waiver participants.
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix H – Quality Improvement Strategy
• Revises the discovery, remediation and systems improvement processes that will be used for this renewal, and across the OLTL waivers.

Appendix I – Financial Accountability
• Revises the performance measures and quality improvement strategy contained within this appendix.

Appendix J – Cost Neutrality
• Revises Factor D estimates for Waiver Years 3, 4 and 5 (SFY 2015-16, 2016-17 and 2017-18).

## 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) |
|---|---|
| ☐ **Waiver Application** | |
| ☑ **Appendix A – Waiver Administration and Operation** | |
| ☑ **Appendix B – Participant Access and Eligibility** | B-3 |
| ☑ **Appendix C – Participant Services** | C-2; C-3 |
| ☑ **Appendix D – Participant Centered Service Planning and Delivery** | |
| ☐ **Appendix E – Participant Direction of Services** | |
| ☐ **Appendix F – Participant Rights** | |
| ☑ **Appendix G – Participant Safeguards** | G-1 |
| ☑ **Appendix H** | |
| ☑ **Appendix I – Financial Accountability** | |
| ☑ **Appendix J – Cost-Neutrality Demonstration** | J-1; J-2 |

**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:
  Revise performance measures and overall quality improvement strategy

# 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*):
**Pennsylvania''s Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging 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.0279**
**Waiver Number:PA.0279.R04.02**
**Draft ID: PA.013.04.02**

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 07/01/13**
**Approved Effective Date of Waiver being Amended: 07/01/13**

## 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 in42 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:

## 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 Eligiblity 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.
Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver) has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. The Aging waiver provides home and community-based services to persons 60 and over who meet the Nursing Facility level of care and is designed to support individuals to live more independently in their homes and communities and to provide a variety of services that promote community living, including participant directed service models and traditional agency-based service models

The Department of Public Welfare (Department), as the State Medicaid Agency (SMA), retains authority over the administration and implementation of the Aging Waiver. The Office of Long-Term Living, (OLTL) as part of the single SMA, is responsible for ensuring that the Aging Waiver operates in accordance with applicable Federal laws and regulations as well as meeting all 1915 (c) waiver assurances. OLTL maintains oversight of contracted and local/regional entity functions and the development and distribution of policies, procedures and rules related to Waiver operations. OLTL also ensures that waiver services are provided by qualified enrolled Medicaid providers. The OLTL administers Aging Waiver services statewide to all participants who meet programmatic eligibility requirements and are Medicaid eligible.

OLTL retains the authority over the administration of the Aging Waiver, including the development of Waiver related policies, rules and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL retains authority for all administrative decisions and supervision of the organizations OLTL contracts with.

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates the following responsibilities to 52 local Area Agencies on Aging (AAAs):
• Facilitate eligibility determinations for potential waiver enrollees (waiver related enrollment activities);
• Perform the initial level of care determinations for potential Aging Waiver enrollees; and
• Perform annual level of care reevaluations for Aging Waiver participants.
The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and in accordance with all applicable policies and procedures.

Waiver enrollment and Level of Care determinations occur at the local AAAs, again with direct oversight by OLTL. Services are provided through qualified providers that are enrolled as Medical Assistance providers. OLTL has written provider agreements with service providers across the Commonwealth who meet all waiver requirements and are enrolled in Medical Assistance. These local Aging Waiver providers are responsible for direct services to participants. The statewide Vendor Fiscal/Employer Agent executes and holds Medicaid provider agreements with individual support service workers hired by participants choosing to self-direct their services.

## 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. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

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

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

## 5. Assurances

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

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

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 public input process to obtain stakeholder input on the proposed changes included in the Aging Waiver amendment.

Timeline:

Specifically in the drafting of the Aging Waiver amendment, the following strategies were undertaken:
- December 9, 2014 discussed at the Long – Term Care Subcommittee of the MAAC
- December 19, 2014 distributed via the OLTL ListServ and posted on the OLTL website
http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm
- December 20, 2014 Public Notice was published in the Pennsylvania Bulletin
- January 6 and January 8, 2015 hosted webinars for all interested stakeholders
- January 8, 2015 notification sent out to various stakeholders, including waiver participants, through the Disability Rights Network
- January 22, 2015 discussed at the Medical Assistance Advisory Committee
- February 10, 2015 Comments were reviewed at the Long – Term Care Subcommittee of the MAAC

Participant involvement:

The Long-Term Care Subcommittee of the MAAC includes participant representation as well as advocacy representation. All members of this committee are responsible for reaching out to their constituencies to make them aware of the information that is presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents. This committee was used as a venue to seek participant and advocate input. Additionally, Service Coordination Entities were asked to share information with Aging Waiver participants.

Summary of Public Input Opportunities:

The required public notice was conducted for the proposed Aging Waiver amendments as follows. On December 19, 2014, OLTL distributed the public notice announcing the availability of the waiver amendment documents via the OLTL ListServ and posted it on the OLTL website at http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm. In addition, a Public

Notice was published in the Pennsylvania Bulletin on December 20, 2015, which is distributed electronically and in paper format via subscription. The official public comment period ended on February 3, 2015.

OLTL made public comment opportunities available via written and mailed submissions, a dedicated email site, direct contact to OLTL staff, or verbally at one of the public webinars held in January. While no formal comments were made by those participating on the webinars, clarifying questions were asked and were responded to. Written feedback was received from advocates/advocacy organizations. Feedback was carefully considered and incorporated as appropriate following the public comment period in this submission of the waiver amendment. Stakeholder comments, and OLTL's responses, will be posted on OLTL's website at: http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/oltlwaiverinfodec14/index.htm

**J.** **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K.** **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:** 625 Forster Street

**Address 2:** 321 Health and Welfare Building

**City:** Harrisburg

**State:** **Pennsylvania**

**Zip:** 17120

**Phone:** (717) 787-2600 **Ext:** ☐ **TTY**

**Fax:** (717) 772-2062

**E-mail:** leallen@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 22, 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 & Welfare Building

**City:** Harrisburg

**State:** **Pennsylvania**

**Zip:** 17120

**Phone:** (717) 787-2600 **Ext:** ☐ **TTY**

**Fax:** (717) 772-2062

**E-mail:** leallen@pa.gov

## Attachments

**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:

OLTL removed the exceptions for a representative payee or power of attorney (POA) to provide services within Appendix C. On April 16, 2015, OLTL advised service coordinators to begin working with participants who would be impacted by this change to assist them in finding alternative providers or alternative representative payees or POA's prior to July 1, 2015. As of October 1, 2015, all participants who were utilizing a POA or representative payee as their paid caregiver have been transitioned to alternative providers.

Participants have the right to request a fair hearing if changes in the amendment result in a denial, reduction, termination, or suspension of their services. Participants will be informed of their opportunity to request a fair hearing when Service Coordinators issue a Notice of Service Determination and the Right to Appeal form to each participant whose services are affected by changes in the amendment.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The Office of Long-Term Living (OLTL), in accordance with and related to new Home and Community-Based Services (HCBS) Settings regulations found at 42 C.F.R. §441.301(c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), is submitting a plan detailing actions to achieve compliance with the Setting requirements for the Aging Waiver.

Timeline:
The HCBS transition plan for the Aging Waiver was first submitted to CMS on June 30, 2014. Prior to submission, a series of public comment opportunities were provided to stakeholders and interested parties:
• May 17, 2014 a 30-day public comment period was initiated through a Public Notice published in the Pennsylvania Bulletin
• May 23, 2014 the transition plan was distributed to various stakeholders via the OLTL ListServ and posted on the OLTL website http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/index.htm
• June 10, 2014 the transition plan was discussed at the Long – Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC)
• June 13, 2014 the transition plan was discussed at the OLTL HCBS Provider meeting
• June 26, 2014 the transition plan was discussed at the MAAC meeting

Based upon CMS and stakeholder feedback, OLTL made multiple revisions to the initial transition plan and began a second 30-day public comment period on November 26, 2014.

The required public notice was posted and the second comment period was achieved according to the following schedule:
• October 14, 2014 discussed the transition plan at the Long – Term Care Subcommittee of the MAAC
• November 26, 2014 transition plan was distributed via the OLTL ListServ and posted on the OLTL website http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm
• November 29, 2014 Public Notice was published in the Pennsylvania Bulletin
• December 8 and December 10, 2014 OLTL hosted webinars for all interested stakeholders
• December 10, 2014 notification was sent out to various stakeholders, including waiver participants, through the Disability Rights Network

Participant involvement:
The Long-Term Care Subcommittee of the MAAC includes participant representation as well as advocacy representation. All members of this

committee are responsible for reaching out to their constituencies to make them aware of the information that is presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents. This committee was used as a venue to seek participant and advocate input.

Additionally, Service Coordinators and direct service providers were asked to share information with Aging Waiver participants.

Summary of Public Input Opportunities:
OLTL's transition plan was developed with stakeholder input including public comment through multiple modes. It is OLTL's intent to comply with the new rule and implement a transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families.

As required by CMS, OLTL began a period of 30 days for public comment for the transition plan. With an initial public notice publication on May 17, 2014 in the Pennsylvania Bulletin, OLTL began its official public comment period on May 23, 2014 with the second notice via distribution through the OLTL ListServ. Based upon CMS and stakeholder feedback, OLTL made multiple revisions to the initial transition plan and initiated a second 30-day public comment period on November 26, 2014.

OLTL made public comment opportunities available via written and mailed submissions, a dedicated email site, direct contact to OLTL staff, or verbally at one of the public webinars held in December. While no formal comments were made by those participating on the webinars, clarifying questions were asked and were responded to. Written feedback was received from multiple advocates/advocacy organizations and other stakeholders. All comments and suggestions received were carefully considered and incorporated as appropriate following the public comment period in this submission of the waiver amendment and transition plan.

Feedback has been categorized and summarized below.

Summary of Comments Received to the Aging Waiver Amendment and Transition Plan During First Comment Period by Plan Component:

Identification
No comments received for this section of the plan.

Assessment
1. While the physical setting and appearance of our Centers may vary, we are bound by a common regulatory process and oversight. The PA Department of Aging licensing division insures our provision of Person Centered Care that is regulated by our Care Plan Systems and demonstrated through our activity based programs.

OLTL response: DPW appreciates the role that Department of Aging licensure plays in Adult Daily Living Centers but is held to CMS regulation. The provisions of the OLTL transition plan will allow OLTL to gain a full understanding of whether and how these Centers comply with the new rule.

2. We understand that OLTL is currently looking at a handful of Centers that, due to their physical locale, may be viewed as restrictive in environment (by CMS criteria). PADSA believes strongly these centers are HCBS based on the services the centers provide and who they provide them to. PADSA will be happy to work as a liaison between the Centers in question and OLTL.

OLTL response: OLTL will be assessing these centers to ascertain their compliance or non-compliance with the rule.

3. We support the OLTL's efforts to seek guidance regarding the Commonwealth's ongoing authority to provide Waiver services to residents of Domiciliary Homes (Dom Care).

OLTL response: Based upon OLTL's initial assessment of its waivers, a small number of waiver participants have been identified as living in Domiciliary Care Homes. As stated in OLTL's draft transition plan, OLTL intends to conduct additional analysis to ensure that these settings are compliant with the new regulations so they may continue to be offered as a choice to waiver participants.

4. Insufficient proof of compliance. DPW makes general claims and assumptions that all OLTL waivers comply with the new regulations. The plan provides no documentation of how OLTL has determined that the current Individual Service Plan (ISP) planning process and every setting complies with the new regulations. The plan omits several new regulatory provisions altogether. DPW at the same time admits there are compliance areas that "will be strengthened" or "will receive additional evaluation" (page 4, 7). DPW only highlights segregated Adult Daily Living Centers, but numerous services are provided across the state in numerous settings. Thus, DPW's claims that OLTL waivers are compliant are unsupported and do not allow for meaningful public input into a full transition plan.

OLTL response: OLTL will use the transition process to prove or disprove compliance with participant-centered planning and allowable setting requirements contained in the CMS rule. This process will consist of development and implementation of a service coordination monitoring tool to gain an understanding of how participant view their services. It will also entail a self-assessment by providers, which will simultaneously train them about the new rule and assist OLTL in gaining their perspective on compliance issues. OLTL's Quality Management Efficiency Teams will conduct a thorough assessment of Adult Daily Living Centers to assure compliance with the participant-centered planning requirements of the CMS rule. A survey of participants will also be conducted to ensure compliance with the participant-centered provisions of the CMS rule.

5. Lack of appropriate assessment. Relatedly, DPW has not documented any specific assessment of the ISP planning process or of every

setting. Further, OLTL proposes that providers assess themselves for compliance. Self-assessment is not appropriate and greatly risks self-serving reporting of compliance to avoid legal obligations.

OLTL response: As mentioned above, self-assessment is only one element in the investigatory phase and it will not be the sole or primary determiner of compliance.

6. The plan's lack of details are as follows: • Regulations are listed with no steps for compliance (pages 2-3) • Unidentified policies and regulations may be revised• Unidentified service coordinator training and/or "monitoring tool[s]" (pages 5, 8, 9) may be developed• Non-compliance and steps for compliance may be identified in the future• "Work plans" will be developed in the future (pages 3, 5, 8)

OLTL response: In the upcoming 120 days, OLTL will begin to develop a statewide transition plan for all of its waivers which will contain specific action steps, timelines and outcomes. This statewide plan will be subject to another 30-day public comment period. In addition, OLTL plans to hold regional face to face public meetings in order to ensure persons with disabilities and their family members are involved in the development and implementation of the transition plan.

7. Once the Service Coordination Monitoring Tool is developed, we would like more information about this, including who will complete…if the Service Coordinator is to complete, will it be a billable activity?

OLTL Response: OLTL is currently working with a small group of Service Coordinators to develop the monitoring tool, which will be subject to stakeholder review and input. Service Coordinators will be trained on use of the tool and will be responsible for its completion. Use of the tool will be a billable activity as part of the service coordination process.

8. We have a specific concern about a service setting which is not mentioned in the transition plan but appears to be non-compliant with the federal regulations at 42 CFR § 441.30l(c)(4). Specifically, certain providers whose personal care home (PCH) licenses were revoked by the Department's Bureau of Human Services Licensing (BHSL) for non-compliance with personal care home licensing regulations have reinvented themselves as waiver providers, providing waiver services in the same buildings they formerly operated as personal care homes, effectively isolating individuals and deterring their health and welfare in these few Philadelphia facilities.

OLTL Response: OLTL cannot comment without knowing more about the specific provider. However, as part of OLTL's assessment and discovery process, residential providers will be required to do a self-assessment and Quality Monitoring Efficiency Teams will conduct on-site visits to survey for compliance with the CMS rule. As part of its regular course of business, when OLTL is contacted with this type of complaint, OLTL conducts an investigation and, if appropriate, refers the complaint to the appropriate regulatory and or law enforcement entities.

9. We encourage OLTL to be flexible in their interpretation of home and community-based settings and not prescriptive which may limit access and choice.-The setting is integrated in, and supports full access to, the greater community.-The setting is selected by the individual from among setting options.-Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.-Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices.-Facilitates choice in services and who provides these services.

OLTL Response: OLTL concurs; available affordable, accessible housing has been consistently recognized as a barrier for providing home and community-based services, especially for those individuals transitioning from nursing facilities. The step in OLTL's draft transition plan which describes amending the Personal Assistance service definition to clearly identify that services are provided to participants that reside in a "private home" has been removed, as OLTL recognizes that it may in fact be perceived as restricting. As part of OLTL's assessment and discovery process, OLTL may determine that changes/clarifications need to be made in current service definitions or new service definitions developed.

Remediation
10. The transition plan should include a plan, with stakeholder participation, to explore and facilitate the development of a wider array of housing options for this population.

OLTL response: OLTL concurs; available affordable, accessible housing has been consistently recognized as a barrier for providing home and community-based services, especially for those individuals transitioning from nursing facilities. As part of OLTL's assessment and discovery process, OLTL may determine that changes/clarifications need to be made in current service definitions or new service definitions developed. In addition, OLTL plans to hold regional face to face public meetings in order to ensure persons with disabilities and their family members are involved in the development and implementation of the transition plan.

Outreach and Engagement
11. The Transition Plan makes several references regarding a stakeholder input process : "To ensure OLTL has robust stakeholder input, OLTL's established stakeholder review process will be used to inform the development of any new policies." We are unclear about this referenced process.

OLTL Response: OLTL currently uses the Long Term Care Subcommittee of the Medical Advisory Committee as the venue in which to solicit input on policy and operational matters. OLTL also uses small stakeholder workgroups as appropriate when developing policies. During the transition process, use of this committee will continue and public input meetings will be held to garner additional input.

12. Recommend that this review process include, at a minimum, both (1) regular, ongoing, formally scheduled forums for people with disabilities and families to provide input into the design and structure of programs and policies (reaction/response to policies or programs the

Department develops alone is not sufficient) and (2) a standard process for distribution of information, outreach and request for input on draft policies that ensures adequate time for meaningful public input.

OLTL response: The Department will be conducting regional public input meetings to secure the widespread input that the commentator seeks. Additionally, OLTL will continue to use its existing stakeholder input process. All meetings of the Long Term Care Subcommittee are sunshined and open for the public to attend and participate in.

Other comments to Transition Plan
13. Although we fully support the OLTL's desire to increase the number of unduplicated persons served in the Waiver, we would also appeal to the OLTL to take advantage of this opportunity to submit other changes to the Waiver that were identified as "parking lot" issues upon the recent renewal of the Waiver.

OLTL response: OLTL must increase the number of unduplicated recipients in the Aging, Attendant Care and Independence waiver for the current Fiscal Year prior to June 30, 2014. This type of amendment, known as a Factor C amendment, may be done retrospectively to the beginning of the fiscal year. The amendments which you are recommending must be submitted prior to implementation as required by the new CMS rule. The overall "parking lot" concerns raised by the commentator are still under analysis for future consideration.

14. It is our understanding that the OLTL is currently reviewing a set of findings and recommendations made by Mercer, LLC to address a number of process and procedural issues related to Participant Access and Eligibility and Participant-Centered Planning and Service Delivery. We would encourage the OLTL to review the findings of the Mercer engagement with stakeholders, prior to the submission of the proposed amendment, and incorporate mutually agreed upon recommendations in the proposed amendment to the Wavier.

OLTL response: OLTL must increase the number of unduplicated recipients in the Aging, Attendant Care and Independence waiver for the current Fiscal Year prior to June 30, 2014. This type of amendment, known as a Factor C amendment, may be done retrospectively to the beginning of the fiscal year. The amendments which you are recommending must be submitted prior to implementation as required by the new CMS rule. OLTL continues to analyze the findings of the Mercer study and potential changes would be addressed by future waiver amendments

15. We would emphasize the need to reinstate Extermination Services as a covered service under the Waiver and add Interpreter Services as a Waiver service, which "may be offered as a waiver service" (Appendix B-8, CMS Instructions for 1915(c) HCBS Waiver).

OLTL response: OLTL must increase the number of unduplicated recipients in the Aging, Attendant Care and Independence waiver for the current Fiscal Year prior to June 30, 2014. This type of amendment, known as a Factor C amendment, may be done retrospectively to the beginning of the fiscal year. The amendments which you are recommending must be submitted prior to implementation as required by the new CMS rule. At this time, OLTL has no plans to add these services to the Aging waiver.

16. We support increasing the number of participants in the Waiver Programs.

OLTL response: Thank you for your concurrence on the amendments.

27. We support OLTL's plan to strengthen its compliance with 42 CFR § 441.301 (c)(l )(iv), which requires the service planning process to reflect the cultural considerations of the individual and be conducted in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency, but more detail is needed.

OLTL Response: OLTL’s transition plan includes a remediation strategy that addresses training for Service Coordinators in the area of person-centered planning as a whole, with areas of focus in cultural considerations and conflict resolution.

Summary of Comments Received to the Aging Waiver Amendment and Transition Plan During Second Comment Period by Plan Component:

Identification
1. List of key stakeholders should be made public. All assessment findings of policies etc. should be made public.
OLTL Response: OLTL will make assessment findings available to the public. Stakeholders include all OLTL providers, members of the Long-Term Care Sub Committee of the MAAC, and other interested individuals who self-identify. In addition, depending on the action step within the transition plan, the stakeholders involved may differ.
2. The plans should describe how key stakeholders were identified.
OLTL Response: OLTL will use its current LTCS in addition to distributing materials to our list serves for review and comment, and hosting webinars for public review and comment.

Assessment
1. The transition plan should indicate that the Provider Self-Assessment tool will be issued to every provider enrolled in each waiver to ensure a comprehensive assessment of settings.

OLTL response: OLTL plans to distribute the Provider self-survey to all OLTL waiver providers.

2. DRN supports doing on site visits of every setting. The transition plan should be clear that pursuant to the new regulations, every setting in which any waiver service is provided-residential and non-residential, licensed and unlicensed-will be evaluated.

OLTL response: OLTL intends to use its current provider monitoring process to monitor provider settings in addition to the participant

monitoring tool and the Provider Self-Assessment tool to identify areas of potential non-compliance.

3. DHS should issue a report of providers that share an address with or are immediately adjacent to an unallowable setting.

OLTL response: OLTL will share the results of assessment activities with the public through its website, advisory group meetings, and other venues as indicated in the transition plan. (Section 2-Assessment # 8).

4. On site visits should include participants, especially those in segregated settings such as personal care homes, sheltered workshops, and segregated day programs; this could be done with the participant monitoring tool.

OLTL response: OLTL intends to have its service coordinators use the participant monitoring tool when they conduct face-to-face visits to ensure participants are receiving services in the most integrated settings that comport with the HCBS rule.

5. Regarding assessment #8- DHS's reports of assessment results should include: provider, compliance status, location, services provided, waivers involved, number of participants served, and number of participants under 21. No personal identifiable or confidential information should be publically disclosed.

OLTL response: OLTL agrees and this was added to the transition plan. OLTL ensures that all materials are properly redacted prior to sharing with the public.

6. More information needs to be provided to understand how the Department plans to use GIS.

OLTL Response: GIS will assist OLTL in identifying HCBS providers that share an address with an institution as well as providers that are immediately adjacent to a public institution.

7. We urge the Department not to rely primarily on self-reports concerning compliance, instead we urge you to consider licensing information, provider qualification reviews and support coordinator reports, conduct site visits as necessary: and solicit input from consumers and advocates.

OLTL Response: OLTL agrees with this comment and will not be relying solely on the provider self-assessment. OLTL intends to use the self-assessment as an initial tool to evaluate and prioritize the on- site visits. OLTL will be considering the use of the provider self-assessment tool as part of the regular ongoing monitoring to ensure ongoing compliance. In addition, OLTL will be utilizing the participant monitoring as a way to evaluate settings.

8. We also urge the Department to seek and consider input from stakeholders and the public as you gather data concerning whether services are being provided in unallowable settings and settings which are presumed not to be eligible. Consumers and disability and aging advocates (including ombudsman programs have knowledge gained from experience which should be included in the data under consideration.

OLTL Response: OLTL will offer opportunity for public input on its determination of compliant and non-complaint settings.

9. We are pleased that OLTL plans to share the results of its assessment activities with the public. In particular, there should be public notice of settings/providers that have been determined unallowable and ask that there be an opportunity for comment as well. We ask that there be an opportunity for comment on settings which are presumed unallowable (for example because they are co-located in a nursing facility) but the Department determines that the setting is in fact home and community based, including the plan to achieve compliance.

OLTL Response: OLTL will comply with CMS requirements on disclosure of findings.

10. DHS needs to develop and implement processes to detect settings which may present themselves as "independent housing" but which in fact are provider-owned or controlled boarding homes.

OLTL Response: OLTL will identify these settings through the Provider self-assessment, the participant monitoring tool and follow-up visit by our Quality Management Efficiency Teams (QMET).

11. DHS should collaborate with the Department of Health to determine whether home health or personal care agencies which they license also provide housing to waiver consumers.

OLTL Response: OLTL will consider this recommendation as we move forward with the Assessment phase of the transition plan.

12. Having consumer satisfaction assessed by the Supports Coordinator seems unwise if you expect waiver participants to speak freely. And written surveys are unlikely to be returned by those with brain injury. What is your objection to having an outside organization perform a phone survey of all participants?

OLTL Response: The participant monitoring tool referenced in the transition plan is not intended to measure only consumer satisfaction. OLTL has a separate participant satisfaction survey that we issue directly to participants on a quarterly basis. The participant monitoring tool is to assess whether participants are receiving the services that are needed and are residing in a compliant setting.

13. We strongly urges OLTL to take full advantage of the discretion it has to present evidence to CMS that certain non-residential Adult Daily Living service settings meet the HCBS requirements regardless of their physical location.

OLTL Response: OLTL will take this comment into consideration. OLTL will look at each setting on a case by case basis.

14. We recommend OLTL to define the term "greater Community" which is referenced but undefined by CMS.

OLTL Response: OLTL will work with other Department of Human Services offices in further defining terms as they relate to the HCBS final rule and the statewide transition plan.

15. We urge OLTL to include an action step that would establish a mechanism to share the consumers ISP with each of the consumer's providers to ensure continuity of services.

OLTL Response: OLTL does not require service coordinators to provide the entire service plan to all providers to protect participant privacy. However, they are required to provide a Service Authorization Form that contains the information related to the services required from that specific provider.

Remediation
16. The transition plan should provide for a policy that no new participant can get services in a non-compliant or presumptively non-compliant setting.

OLTL response: Providers that are non-compliant will be issued corrective action plans that may or may not include a moratorium on serving new participants depending on the type and degree of non-compliance found during the assessment process.

17. The plan should state that DHS will not allow new provider, provider moves, or expansion of providers in settings that are non-compliant or presumed non-compliant.

OLTL Response: OLTL will look at this on a case by case basis based on the outcome of the assessment and provider circumstances. For example, a provider may need to move operations to bring them into compliance. However, OLTL agrees that new providers will not be enrolled if they are non-compliant or presumed non-compliant.

18. Presumptively non-compliant settings should not remain in the system. The QMET on-site monitoring tool to be used should be revised through a public comment process to include all regulatory requirements. DHS should share with the public the evidence it intends to submit to CMS and follow all public notice and public comment requirements for settings presumed non-compliant.

OLTL Response: OLTL will comply with CMS requirements on disclosure of findings.

19. The transition plan should have steps to develop services, supports, and opportunities for people with disabilities to seek and obtain competitive employment.

OLTL Response: As stated in the transition plan, OLTL will review policies, regulations, and procedures including evaluating waiver service definitions related to employment.

20. OLTL should specify concrete actions to build provider capacity rather than vaguely stating "it will develop a strategy to expand the provider base".

OLTL Response: OLTL believes an assessment, with stakeholder input, is necessary to inform our strategy to build capacity moving forward.

21. # 10 should state that persons who will have to transfer from non-compliant or presumed non-compliant settings will get advance, accessible notice through a phone call and/or visit from the Service Coordinator in addition to a letter, which will ensure that this important information is received and understood.

OLTL Response: OLTL has modified the plan to include this language. In addition, 55 Pa. Code § 52.61 outlines requirements for provider cessation of services.

22. #11 section should be revised to "Service Coordinators will work with participants to offer choices of qualified waiver providers that comply with the new regulations and to choose from among integrated settings to receive services, through person-centered planning, and facilitate a safe, timely transition to the chosen new provider. OLTL will work directly with providers to develop programs and services in compliant settings when needed to ensure participants' access to services in the community.

OLTL Response: OLTL agrees with the comment and has added it to the transition plan.

23. The participant monitoring tool needs revision.

OLTL Response: The participant monitoring tool will go through a pilot phase beginning January 5, 2015 through March 2015. OLTL will be revising the participant monitoring tool as a result of any findings and suggestions in the pilot phase.

24. OLTL (DHS) should use Relay and other effective communication to ensure access to its hotline for reporting non-compliance. DHS should also allow for email and communication with service coordinators for reporting non-compliance.

OLTL Response: The Commonwealth has a contract with PA Relay and uses it to communicate with individuals who are deaf or hard of hearing.

25. Proposed changes to licensing requirements, policies or provider standards should be shared with stakeholder groups for comment.

OLTL Response: OLTL currently circulates all drafted policies and procedures to the Long-Term Care Sub Committee of the MAAC for stakeholder review and comment.

26. It is essential that the quality assurance process operate in a timely and effective manner to require compliance and relocate consumers if OLTL plans to rely on its existing quality assurance structure.

OLTL Response: OLTL will take this comment into consideration as we move forward with the transition plan.

27. We encourage OLTL to include rate reviews and adjustment where necessary as a specific action step to address developing and maintaining an adequate provider base.
OLTL Response: OLTL will work with other Department of Human Services Offices on provider capacity issues as relate to the HCBS final rule and the statewide transition plan.

Outreach and Engagement
28. Use plain, first person language and all communications should be accessible. Email lists, service coordinator visits, local meetings, work groups and advisories should be part of education and outreach. DHS should involve self-advocates and peer training.

OLTL Response: OLTL currently uses email lists and webinars to provide education and outreach to our stakeholders. OLTL will seek input from stakeholders on the best way to reach participants for comment on the HCBS transition plan. OLTL will use our key stakeholders to assist in identifying ways to reach and involve participants in the process.

29. Stakeholders need to be involved before policies become final. The plans should state that DHS will notify the public about proposals to revise policies and have public comment periods. All proposed changes should go through public comment via the PA Bulletin and regulatory review process.

OLTL response: OLTL currently circulates all drafted policies and procedures to the Long-Term Care Sub Committee of the MAAC for stakeholder review and comment as well as distributing materials through our list serve for public review and comment. OLTL will utilize the Pennsylvania Bulletin to communicate substantive changes to the HCBS transition plan.

30. All tools and materials should go through the public comment process this includes all deliverables within the transition plan.

OLTL Response: OLTL has received public input through the Long Term Care Subcommittee of the Medical Assistance Advisory Committee on the participant monitoring tool and we will continue to use that process in addition to using our email list serves for the Provider self-survey and any subsequent materials.

31. We urge the Department to seek input from consumers and advocacy groups about areas in which community integration should be strengthened and which the transition plan could address. For example, employment related services.

OLTL Response: Once the Assessment phase is completed, OLTL will seek stakeholder input on further changes.

32. We recommend including an action step to form a work-group of non-residential stakeholders and providers to serve as an advisory body for the implementation of the transition plan.

OLTL Response: OLTL currently uses the LTC Sub Committee of the MAAC as the venue in which to solicit input on policy and operational matters. OLTL also uses small stakeholder workgroups when developing policies. During the transition process, use of these workgroups will continue and public input meetings will be held to garner additional input.

Other comments to Transition Plan
33. The vagueness of the CMS settings requirements means that each person may need to be interviewed to understand how they are meeting the government's goals – whether they want to be integrated within their local community or not. What about people who choose not to integrate? How will that affect the rating of the provider's compliance? Brain injury families and survivors on the Independence Waiver were just recently relocated – and now may face another move. Can you provide 6 months' notice for any required moves?

OLTL response: OLTL is required to follow all of CMS requirements in determining allowable settings. Timeframes for transition will be determined based on person centered service planning and provider circumstances.

The Transition Plan associated with this waiver amendment reflects these comments and suggestions as applicable to the overarching, preliminary design of this initial planning. The state, through the development of the Statewide Comprehensive Transition Plan, will bring this feedback to the next level of transition planning as we embark collectively with our stakeholders in the next 120 day planning phase.

The OLTL Home and Community Based Services Transition Plan-Aging Waiver:

Section 1: Identification – The Office of Long-Term Living (OLTL) will use its transition plan as a way to determine its compliance with

CMS' rule on HCBS. OLTL will determine the current level of what state actions are needed for compliance. This will include a review of current licensing requirements, policies, regulations, rules, standards and statutes.

A. Submit Waiver Amendments
- Description: OLTL will submit waiver amendments.
- Dates: Sep-14 – Dec-14
- Deliverable: Waiver submitted to CMS

B. Obtain Providers By Setting
- Description: OLTL will obtain providers by setting.
- Dates: Sep-14 – Dec-14
- Deliverable: Report of Providers by setting

C. Review of Policy Documents, Regulations, and provider requirements
- Description: OLTL will identify Pennsylvania regulations, Waiver service definitions, policies and provider standards to identify changes needed to comply with the HCBS rules. This will include review of enrollment requirements and processes, licensure regulations, programmatic regulations and other policy documents.
- Dates: Sep-14 – Dec 14
- Deliverable: Report of Policies, provider standards and waiver service definitions that need to be revised/updated to comply with the HCBS rule.

D. Identify Key Stakeholders
- Description: OLTL will identify key stakeholders.
- Dates: Sep-14 – Dec-14
- Deliverable: List of key stakeholders

Section 2: Assessment – OLTL's assessment activities will include a review of policy documents and provider enrollment documents, a review of licensing requirements, development and implementation of a provider self-assessment and development and implementation of a participant monitoring tool. Data from these activities will be assessed and provider settings will be place into three categories: (1) Setting is fully compliant; (2) Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and (3) Setting does not comply. These categories will inform the order in which OLTL will perform on-site visits, starting with settings that do not comply and ending with settings that the assessments indicate are fully compliant. These activities will give OLTL a provider and participant perspective on settings, which will be followed by official OLTL on-site monitoring's to validate compliance status. A. Development of provider Assessment Tools.

Internal Assessment (Regulations, Policies, Procedures)

A Review of Policy Documents, Waiver service definitions and Provider Enrollment Requirements
- Description: OLTL will identify Pennsylvania regulations, Waiver service definitions, policies and provider standards to identify changes needed to comply with the HCBS rules. This will include review of enrollment requirements and processes, licensure regulations, programmatic regulations and other policy documents.
- Dates: Sep-14 - Dec-14
- Deliverable: Report of Policies, provider standards and waiver service definitions that need to be revised/updated to comply with the HCBS rule

B. Evaluate licensed and unlicensed settings
- Description: OLTL will work with the Bureau of Human Services Licensing (BHSL) and the Department of Aging (PDA) when applicable to identify settings that are licensed by each entity to determine compliance with the HCBS rule.
- Dates: Sep-14 - Complete
- Deliverable: 2,582 Aging Waiver participants receive Adult Daily Living Services in 121 settings which are licensed by the Department of Aging, 8 centers have been identified as a setting presumed non-compliant but evidence may be presented for heightened scrutiny review; Six Aging waiver participants reside in Domiciliary Care homes. These individual provider homes are private household or family dwellings and serve no more than three Dom Care residents. These settings are under the regulatory jurisdiction of the PA Department of Aging, and are inspected annually by the local Area Agency on Aging (AAA) to ensure they meet health and safety standards. If the home and provider passes this inspection, they are certified by the AAA.

C. Review of Licensing Requirements
- Description: OLTL will collaborate with the Bureau of Human Services Licensing (BHSL) and the Department of Aging (PDA) to identify any necessary changes to policies or other licensing requirements in order to comply with the HCBS rule.
- Dates: Sep-14 Dec-14
- Deliverable: List of identified changes that need to be made

D. Identify IT changes that are necessary for data collection on compliance with the HCBS rule
- Description: Identify changes needed and, where necessary, develop temporary methods and tools to collect, analyze, and audit provider information until permanent IT system changes can be implemented.
- Dates: Nov-14 – Dec-14
- Deliverable: identified IT changes

Provider Assessment

A. Geographic Information System (GIS) Evaluation of HCBS Provider Locations and Participant Addresses
- Description: OLTL will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentrations of HCBS providers and participants.
- Dates: Sept-14 – Dec-14
- Deliverable: Report of HCBS Providers that share an address with Unallowable settings

B. Develop and test Provider Assessment Tool
- Description: OLTL will develop an electronic Provider Self-Assessment tool to assist in identifying those settings that do not meet the regulations set forth in the HCBS final rule. Results of the Self- - Assessment tool will assist OLTL prioritize and conduct onsite provider monitoring.
- Dates: Sept-14 – Dec-14
- Deliverable: Electronic Provider Self-Assessment tool.

C. Complete/Collect Provider Self- Assessment
- Description: OLTL administers Self-Assessment tool to capture needed elements to ensure compliance with the HCBS rule.
- Dates: Dec-14 – Feb-15
- Deliverable: Distribution of the Provider Self- Assessment and collection of results

D. Analyze Data
- Description: OLTL will compile and analyze data from the Provider Self-Assessments and the Participant Monitoring tool as they potentially conform to HCBS characteristics and their ability to comply in the future. Settings will be classified into the following categories: (1) Yes. Setting is fully compliant; (2) Not Yet. Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and (3) No. Setting does not comply. Please see attached Settings Analysis.
- Dates: Feb-15 – Mar-15
- Deliverable: Categorization of Compliance

E. Determine Need For On-Site Assessment Based On Findings Of Self- Assessment
- Description: Based on the Category in which a provider falls, OLTL's Bureau of Quality and Provider Management will prioritize a schedule for on-site compliance monitoring visits. Those reported as #2 and #3 above will receive on-site visits in the first 6 months of this transition plan. In addition, to further validate the results of the provider self-assessment, OLTL's Quality Management Efficiency Teams (QMET) will complete on-site visits to a representative sample of those settings categorized as #1 within the first 6 months. All other settings will be visited by March, 2017.
- Dates: Mar-15 – Mar-15
- Deliverable: Schedule of On-site visits

F. Identify Access issues
- Description: OLTL will identify where there may be access issues based on the categorization of compliance.
- Dates: Feb-15 – Mar - 15
- Deliverable: Identified areas with access issues

G. Perform On-Site Visit
- Description: A representative sample of settings categorized as #1 as well as all those reported as #2 and #3 above will receive on-site visits in the first 6 months of this transition plan. All other settings will be visited by March, 2017.
- Dates: Feb-15 – Mar -15
- Deliverable: Completed visits

H. Report Results
- Description: OLTL will share the results of assessment activities with the public through its website, advisory group meetings and other venues.
- Dates: Mar-15 – Mar-15
- Deliverable: Report of Results

I. Develop Participant Monitoring Tool
- Description: OLTL will develop a Participant Monitoring Tool to be used by service coordinators during face-to-face visits that incorporates questions designed to receive participant feedback on the settings in which they receive services.
- Dates: Aug-14 - Dec-14
- Deliverable: Draft Participant Monitoring Tool

J. Test and Refine the Participant Monitoring Tool
- Description: OLTL pilots the tool to ensure it adequately captures needed elements and is easily and accurately completed by service coordinators.
- Dates: Jan-15 - Mar-15
- Deliverable: Finalized Participant Monitoring Tool

K. Statewide Rollout of the Participant Monitoring Tool
- Description: All service coordinators are trained in the use of the Participant Monitoring Tool and statewide use of the tool begins.

- Dates Apr-15 - Apr-15:
- Deliverable: Statewide Rollout

Modification of Provider Enrollment Process

A. Determine changes needed to integrate assessment findings
- Description: OLTL will evaluate current enrollment application forms to determine any necessary changes to comport with the HCBS rule.

- Dates: Sep-14 - Nov-14
- Deliverable: Provider Standards for enrollment and continued participation

B. Modification Of Surveys & Enrollment Processes
- Description: OLTL will update current provider enrollment forms, applications and checklist, to incorporate the HCBS rules into existing procedures.
- Dates: Nov-14 - Apr-15
- Deliverable: Updated Enrollment application and forms

C. Communicate Changes
- Description: OLTL will send providers necessary forms verifying compliance with the HCBS rule.
- Dates: Dec-14 - May-15
- Deliverable: Standard letter along with updated materials for providers

D. Provide Training
- Description: OLTL will provide webinar training on the new Provider Enrollment procedures
- Dates: Dec-14 - Jun-15
- Deliverable: Training

Section 3: Remediation Strategies - OLTL's overall strategy will rely heavily on its existing HCBS quality assurance processes to ensure provider compliance with the HCBS rule. This will include provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The OLTL may also prescribe certain requirements to become compliant. Pennsylvania will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings in a timely manner may be subject to sanctions ranging from probation to disenrollment.

A. Changes to Regulations, Waiver service definitions Policies and Provider Standards
- Description: OLTL will revise Pennsylvania regulations, Waiver service definition, policies and provider standards to assure compliance with the HCBS rules.
- Dates: Dec-14 - Dec-16
- Deliverable: Updated Policies, waiver service definitions and provider standards

B. Develop provider base
- Description: For those areas where access issues have been identified, OLTL will develop a strategy to expand the provider base.
- Dates: Mar-15 - Mar-17
- Deliverable: Strategy for developing an enhanced provider base

C. Changes to Licensing requirements
- Description: OLTL will collaborate with the Bureau of Human Services Licensing (BHSL) and the Department of Aging (PDA) to revise policies and other licensing requirements to assure compliance with the HCBS rule.
- Dates: Dec-14 - Dec-16
- Deliverable: Updated policies and any updated regulatory packages

D. Develop IT requirements and initiate necessary changes
- Description: Develop and implement the necessary IT changes to perform data analysis, and compliance auditing.
- Dates: Dec-14 - Dec-15
- Deliverable: IT Requirements

E. Onsite Assessments
- Description: All providers will be monitored using the updated QMET on-site monitoring tool. Schedule will be based on categorization developed in the assessment phase. (See above)
- Dates: Mar-15 - Mar-17
- Deliverable: On-site monitoring's

F. Issue Statement of Findings to providers on the results of the Onsite Assessments
- Description: If non-compliant in any of the areas under the HCBS rule, issue a statement of findings to providers listing infractions and immediate need for the provider to develop a Corrective Action Plan (CAP).
- Dates: Mar-15 - Mar-17
- Deliverable: Compilation of the Statement of Findings issued to providers

G. Provider Specific Remediation

- Description: Incorporation of the existing QMET CAP process. Provider remediation activities are documented in CAPs which will be requested from providers by the QMETs to correct non-compliance issues. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider will develop a CAP. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The provider needs to demonstrate through the CAP that it can meet the regulations and waiver provider qualifications and develop a process on how to continue compliance in the future.
- Dates: Mar-15 - Mar-17
- Deliverable: CAP for providers who are not in compliance

H. Report Results
- Description: OLTL will share the results of those providers that will require a CAP to come into compliance with any part of the HCBS rule.
- Dates: Mar-15 - Mar-17
- Deliverable: Report of Providers with a CAP

I. Follow-up to the Onsite Compliance Reviews
- Description: The QMET will verify the approved CAP action steps are in place according to the timeframe as written in the CAP. If the CAP is insufficient, OLTL will work with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL will take action against the provider up to and including disenrollment.
- Dates: Mar-15 - Mar-17

J. Provider Sanctions and Termination of Enrollment with OLTL Waivers
- Description: Incorporate requirements of the new HCBS rule into existing process for provider sanctions, including disenrollment from OLTL waivers.
- Dates: Mar-15 - Mar-17
- Deliverable: Updated Provider Termination and sanction process

K. Notify Participants and service coordinators
- Description: OLTL will notify participants of all findings and compliance actions that are being taken. Individuals who will have to transfer from non-compliant or presumed non-compliant settings will get advance, accessible notice through a phone call and/or visit from their Service Coordinator in addition to a letter, which will ensure that this important information is received and understood.
- Dates: Mar-15 - Mar-17
- Deliverable: Notification to participants in the form of a letter, phone call and visit from the Service Coordinator.

L. Transition Participants to Compliant Settings
- Description: If applicable, Service Coordinators will work with participants to offer choice of qualified waiver providers that comply with the new regulations and to choose from integrated settings to receive services. Through person-centered planning, the Service Coordinators will facilitate a safe, timely transition to the new chosen provider. OLTL will provide technical assistance to providers to develop programs and services in compliant settings when needed to ensure participants' access to services in the community. Service coordinators will be responsible to ensure the participant is aware of any appeal rights and process.
- Dates: Mar-15 - Mar-18

M. Ongoing Compliance
- Description: OLTL will utilize the participant monitoring to measure ongoing compliance with the HCBS rule. The participant monitoring tool will be used bi-annually to assess participant's overall satisfaction with services and settings. OLTL will utilize the established Quality Improvement Structure to conduct ongoing provider compliance with the HCBS final rule.
- Dates: Mar-15 - Ongoing

Section 4: Outreach & Engagement - OLTL proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments and through taking public comments in-person at a series of stakeholder forums conducted throughout the state. In addition to posting the transition plan and related materials on the OLTL website, stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums

A. Develop Communication Materials
- Description: Create Transition Plan Website, link to register, public comment mailbox, information handouts, public communication brief.
- Dates: Nov-14 - Nov-14
- Deliverable: Public Notice Document

B. Public Notice & Comment
- Description: Official notification through PA Bulletin beginning the public comment period on waiver amendments/revisions and published draft transition plan including: submission, consolidation, documentation, and review of public comments
- Dates: Nov-14 - Dec-14
- Deliverable: Public Comment Period

C. Stakeholder Communication & Meetings
- Description: Official notifications through statewide bulletins, departmental websites, stakeholder meetings, webinars, and other public forms informing of setting requirements and statewide transition planning activities on the CMS Final Ruling. OLTL will use our key stakeholders to assist in identifying ways to reach and involve participants in the process.
- Dates: On-going

- Deliverable: Summary Document of public input

D. Transition Plan Revision
- Description: Incorporation of stakeholder comment and feedback on OLTL's waiver-specific Transition Plan, submission of final fully developed waiver-specific plan to CMS, and publication of approved plan.
- Dates: January 2016

E. Provider & Stakeholder Training
- Description: On-going engagement highlighting updates and revisions to Pennsylvania's regulations, policies, and procedures; training on compliance to the HCBS Final Rule and transitioning activities for service coordinators, providers, and staff.
- Dates: TBD

F. Ongoing Stakeholder Engagement
- Description: Continued engagement with stakeholder community on regulations and department updates, sustaining an inclusive, person-centric focus that is transparent to individuals and the community while providing accountability to all parties involved.
- Dates: On-going

G. Mechanism for reporting non-compliance by family members or participants.
- Description: Participants will be given the OLTL helpline if they have questions or need additional information regarding a provider's status or a possible transition. Participants will receive this information from their service coordinator in the packet of informational materials developed by OLTL.
- Dates: Mar-15 - Mar-15

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

....Continuation of Appendix-A.3-Contracted Entity

• Maintain funds for individual service budgets separately and with full accounting;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through an appropriate agency;
• Process all judgments, garnishments, tax levies or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
• Establish an accessible customer service system for the participant and the Service Coordinator.

Administration and oversight of these contracts falls within the purview of OLTL and the Office of Medical Assistance Programs (OMAP). The assessment methods used to monitor performance of contracted entities are described in A-1-6 below.

...Continuation of Appendix B. Quality Improvements a.i.b.
Denominator: Total number of waiver participants reviewed

...Continuation of Appendix C. Quality Improvements a.i.b.
Denominator: Total number of new waiver non-licensed/non-certified provider applicants during the reporting period

...Continuation of Appendix C. Quality Improvements a.i.b. (second listing)
Denominator: Total number of non-licensed/non-certified providers reviewed during the reporting period (quarter)

...Continuation of Appendix D. Quality Improvements a.i.a.
Denominator: Total number of waiver participants reviewed

....Continuation of Appendix G Quality Improvements a.i.(fourth listing)
Denominator - Total number of New Waiver participants who responded to the Participant Satisfaction Survey.

....Continuation of Appendix G Quality Improvements a.i. (fifth listing)
Denominator - Total number of "Annual" Waiver participants who responded to the Participant Satisfaction Survey

....Continuation of Appendix I.a.i

The Commonwealth would request an explanation from the vendor who set the rate as to why the correct methodology was not used. A detailed break out of the rate setting process would be examined to determine the cause of the incorrect calculation.

....Continuation of Appendix I.a.ii

The QMET monitoring tool is an Excel based instrument that provides a systematic and comprehensive way to measure and retain information regarding provider compliance. The tool consists of verifications relative to the regulations set forth by OLTL. Each monitoring tool is

prepared as applicable for the ensuing provider review and is specific to the provider and the waiver services for which they are enrolled to provide services. Financial accountability requirements are included in both the SCE tool and the DSP tab labeled financial. The tool calculates if a provider has met or not met each regulation. See attachment A for a copy of the financial accountability requirements in the monitoring tool.

The process of data collection is done by QMET while performing a monitoring review. Information from the monitoring reviews are updated weekly for each provider. That information is then compiled into a monthly reporting form. That monthly reporting form is then utilized to aggregate data for the PMs.

The sampling methodology is based upon a statistical calculation in which we take each of the items (participants/employees/billed claims) required for review and create a sample based off of a confidence rate of 95% (a 95% certainty) and confidence interval (margin of error) of 10. Additionally, QMET has the option of judgmentally adding to this sample at the professional discretion of the reviewer. In cases that the random sample has missed items that are may need attention, or if separate items cause issue or suspicion during a review, those items may be added to our sample.

The State is using the rate methodology in the public notice published at 42 Pa.B. 3343 (June 9, 2012) and subsequent revisions. The state will be able to provide a narrative to prove that the provider payment rates are consistent with the rate methodology approved in the waiver.

OLTL requests permission to remove these two Performance Measures. The FEA vendor prepares the SMW reports. They used the procedure codes unique to Services My Way to determine who was on the program, then did an analysis of the individual spending patterns of the participants. The universe of participants is very small. However, OLTL would like to remove the Services My Way performance measures because while data was collected, it was for a very small amount of participants and did not yield any meaningful results. OLTL removed the Service My Way performance measures for the following reasons: During the last three years, none of the participants were ever removed from the model for any reason other than becoming deceased. There was not any non- authorized use of funds and spending plans were adhered to. However, all of the SMW participants are included and their data is captured within other performance measures, so that that data is part of the overall analysis of waiver effectiveness.

Financial Management Services are not a service in any of OLTL waivers, but has been provided as an administrative activity since January 2013. The Department's F/EA vendor has a contractual relationship with the Commonwealth that was established through a competitive bidding process. All payments to the F/EA, including administrative fees, are specified in the contract and paid through the MMIS system. Administrative fees are not included in the participants' service costs.

....Appendix I.3.f Additional Information

Providers submit claims through PROMISe™ (MMIS system) and provider accounts receivables are automatically established in PROMISe™ when the net reimbursement of a claim adjustment transaction is less than zero.

## 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.
   **The Office of Long-Term Living (OLTL)**
   *(Complete item A-2-a).*

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

   Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

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

   Descriptions of the functions of the operating divisions within the Department, including OLTL and OMAP, are available (through links) on the following Department of Public Welfare website http://www.dpw.state.pa.us/dpworganization/index.htm.. The specific roles and responsibilities of these entities in the administration of the waiver are further delineated in waiver policies and procedures.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   **As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   OLTL retains the authority over the administration of the Aging Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL retains authority for all administrative decisions and supervision of the organizations OLTL contracts with.

   Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL contracts with 52 local Area Agencies on Aging to perform the following responsibilities. Thirty-three of these entities are Local/Regional non-state public agencies, while nineteen are Local/Regional non-governmental non-state entities.
   • Facilitate eligibility determinations for potential waiver enrollees (waiver related enrollment activities). Enrollment activities include:
   o Complete the initial in-home visit;
   o Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider;
   o Provide applicants with choice of receiving Nursing Facility institutional services, home and community-based services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form;
   o Provide applicants with a list of qualified Service Coordination entities and document the individual's choice of Service

Coordinator on the OLTL Service Provider Choice Form;
o Assist the applicant to obtain a completed physician certification form from the individual's physician;
o Refer the applicant to the proper party within the AAA for the level of care determination;
o Ensure the individual's CMI is pre-populated from the LOCA;
o Assist the participant to complete the financial eligibility determination paperwork; and
o Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms as necessary.
• Perform the initial level of care determinations for potential Aging Waiver enrollees; and
• Perform annual level of care reevaluations for Aging Waiver participants.

OLTL also contracts with one non-governmental non-state entity to perform waiver related enrollment activities in counties where the AAA has chosen not to provide waiver related enrollment activities in their service area. Specifically, the Independent Enrollment Broker (IEB) is responsible for the following:
• Complete the initial in-home visit and needs assessment;
• Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider;
• Provide applicants with choice of receiving Nursing Facility institutional services, home and community-based services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form;
• Provide applicants with a list of qualified Service Coordination entities and document the individual's choice of Service Coordinator on the OLTL Service Provider Choice Form;
• Assist the applicant to obtain a completed physician certification form from the individual's physician;
• Refer the applicant to the local AAA for the level of care determination;
• Assist the participant to complete the financial eligibility determination paperwork; and
• Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms.

OLTL also contracts with one Fiscal Employer/Agent entity to perform certain functions for the successful operation of participant direction.
These administrative functions delegated to the FMS by OLTL include:
• Execute Medicaid provider agreements with qualified vendors and support workers;
• Assist in implementing the state's quality management strategy related to FMS;
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis and as requested by the participant, Service Coordinator and OLTL (Budget Authority only).

In addition to these delegated activities, the FMS also serves to:
• Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
• Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees;
• Assist participants in verifying support workers citizenship or alien status;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;

***Please see Main-B-Optional for remaining language.

○ **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 Aging Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL also retains the authority for all administrative decisions and supervision of non-state public agencies that conduct waiver operational and administrative functions.

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates the following responsibilities to 52 local Area Agencies on Aging (AAAs). Refer to Appendix A-3 above for additional details regarding delegated functions.
• Facilitate eligibility determinations for potential waiver enrollees (waiver related enrollment activities);
• Perform the initial level of care determinations for potential Aging Waiver enrollees; and
• Perform annual level of care reevaluations for Aging Waiver participants.

Thirty-three (33) of the AAAs are local county-based organizations - non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and in accordance with all applicable policies and procedures.

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

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

OLTL retains the authority over the administration of the Aging Waiver, including the development of Waiver related policies, rules, and regulations, which are distributed by OLTL through Bulletins and other communications issued electronically. OLTL only delegates specific functions in order to ensure strong quality oversight of the Waiver program. OLTL also retains the authority for all administrative decisions and supervision of non-governmental non-state agencies that conduct waiver operational and administrative functions.
Nineteen (19) of the AAAs are non-governmental non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and in accordance with all applicable policies and procedures.
Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates the following responsibilities to 52 local Area Agencies on Aging (AAAs). Refer to Appendix A-3 above for additional details regarding delegated functions.
• Facilitate eligibility determinations for potential waiver enrollees (waiver related enrollment activities);
• Perform the initial level of care determinations for potential Aging Waiver enrollees; and
• Perform annual level of care reevaluations for Aging Waiver participants.

OLTL also contracts with one non-governmental non-state entity to perform waiver related enrollment activities. The IEB was selected through a competitive procurement process to facilitate eligibility determinations for multiple home and community-based waivers managed by OLTL. As previously stated, the IEB only performs waiver related enrollment activities for the Aging Waiver in those counties where the AAA has chosen not to provide enrollment activities in their respective county or service area. The IEB's responsibilities are outlined above in Appendix A-3.

In addition, OLTL contracts with one Fiscal Employer/Agent (F/EA) entity to perform certain delegated functions for the successful operation of participant direction. The F/EA was also selected through a competitive procurement process; the F/EAs responsibilities are outlined above in Appendix A-3.

## 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 other contracted entities. OLTL provides information and technical assistance to AAAs through the Long-Term Living Training Institute, targeted technical assistance, and upon request.

## 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 during this period of renewal, through work with CMS on a Corrective Action plan, and in response to CMS recommendations on the evidence report, to strengthen the methods for overseeing entities performing administrative

elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring.

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

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

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

Much like its monitoring of the AAAs, OLTL oversees the contractual obligations of the Fiscal Employer Agent (F/EA). QMETs conduct an onsite annual operational review of the contracted F/EA to ensure that all required functions are performed in accordance with all OLTL requirements including the Waiver assurances and the F/EA contract. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In addition to the annual onsite operational review, there is significant oversight conducted on a monthly basis. The contract requires the F/EA to provide OLTL with monthly utilization reports, quarterly and annual status reports, as well as problem identification reports; these reports cover activities performed and issues encountered during the reporting period. OLTL will utilize these reports to monitor performance to ensure services are being delivered according to the contract.

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

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

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

## 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** | ✓ | ✓ | ✓ |
| **Waiver enrollment managed against approved limits** | ✓ | | |
| **Waiver expenditures managed against approved levels** | ✓ | | |
| **Level of care evaluation** | ✓ | | ✓ |
| **Review of Participant service plans** | ✓ | | |
| **Prior authorization of waiver services** | ✓ | | |
| **Utilization management** | ✓ | ✓ | |
| **Qualified provider enrollment** | ✓ | | |
| **Execution of Medicaid provider agreements** | ✓ | ✓ | |
| **Establishment of a statewide rate methodology** | ✓ | | |
| **Rules, policies, procedures and information development governing the waiver program** | ✓ | | |
| **Quality assurance and quality improvement activities** | ✓ | ✓ | |

## Appendix 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 waiver 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***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Bi-annual QMET monitoring visits | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**AA-2: Number and percent of SCEs that meet waiver obligations regarding ongoing level of care determinations Numerator: Total number of SCEs who meet waiver obligation regarding ongoing level of care determination Denominator: Total number of SCEs reviewed**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = Representative Sample + - 5%; Confidence Interval =95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Bi-annual visit by QMET monitoring teams |

**Performance Measure:**
**AA-4: Number and percent of AAAs that meet contractual obligations regarding enrollment Numerator: Total number and percent of AAAs that meet contractual obligations regarding enrollment Denominator: Total number of AAAs 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% + - 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other** Specify: | |

**Data 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**AA-6: Number and percent of contractual obligations met by the FEA regarding the execution of**

**Medicaid provider agreements Numerator: Total number of contractual obligations that were met by the FEA regarding the execution of Medicaid provider agreements Denominator: Total number of contractual obligations of the FEA**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**AA-7: Number and percent of participant distribution by # of participants and 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**AA-8: Number and percent of providers that comply with the 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** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**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 Bureau of Quality & Provider Management (BQPM) reviews AAAs regarding the initial LOC, reevaluations of LOC, F/EA and enrollment functions. The BQPM uses standard monitoring tools which outline the provider requirements as listed in the waiver and the Fiscal/Employer Agent (F/EA) contract, including LOC determination, F/EA, and enrollment functions. The BQPM verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum.

The Independent Enrollment Broker (IEB) supplies data monthly on their contractual obligations to the designated Bureau of Participant Operations (BPO) contract monitor. The contract monitor ensures compliance on 100% of contractual obligations.

The Fiscal/Employer Agent (F/EA) supplies data monthly on their contractual obligations to the designated Bureau of Participant Operations (BPO) contract monitor. The contract monitor ensures compliance on 100% of contractual obligations

The State will follow the sampling methods and timelines as outlined in the waiver specific transition plan.

**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 monitoring reviews identify AAAs are noncompliant with requirements related to Level of Care determinations and/or enrollment functions as outlined in the waiver or grant agreements, the agency receives written notification of noncompliance with a request for a Corrective Action Plan (CAP). The CAP is due to the BQPM within 15 working days upon receipt. BQPM staff reviews and accepts/rejects the CAP within 30 working days. Follow up by the BQPM occurs to ensure the CAP was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue, technical assistance is provided by the Bureau of Quality & Provider Management (BQPM) and the Bureau of Participant Operations (BPO). This same process is also applied to the F/EA when non-compliance is found with contractual obligations regarding the execution of Medicaid provider agreements.

Through a combination of reports from the enrollment broker and administrative data, the Contract Monitor for the Independent Enrollment Broker (IEB) determines if the contractual obligations are being met. If they are not met, BPO notifies the IEB agency of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.

Through a combination of reports from the F/EA and administrative data, the Contract Monitor for the Fiscal/Employer Agent determines if the contractual obligations are being met. If they are not met, BPO notifies the F/EA of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## 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 |
| ☑ Aged or Disabled, or Both - General | | | | | |
| | ☑ | Aged | 65 | | ☑ |
| | ☑ | Disabled (Physical) | 60 | 64 | |
| | ☐ | Disabled (Other) | | | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☐ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☐ | Autism | | | ☐ |
| | ☐ | Developmental Disability | | | ☐ |
| | ☐ | Intellectual Disability | | | ☐ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

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

**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:*

This does not apply as there are no upper limits on age in this waiver. There is an issue with the on-line application where the fields in section B-1 of the application do not allow for entering the minimum age of 60 and no maximum age for the Aged target sub-group.

## 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 | 30000 |
| Year 2 | 35806 |
| Year 3 | 36421 |
| Year 4 | 38891 |
| Year 5 | 41361 |

**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 | 22500 |
| Year 2 | 27956 |
| Year 3 | 27105 |
| Year 4 | 29035 |
| Year 5 | |

## Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

| Purposes | |
|---|---|
| Money Follows the Person rebalancing demonstration | |

## 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):*

Money Follows the Person rebalancing demonstration

**Purpose** *(describe):*

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the Aging Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the Aging Waiver.

**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 | 241 |
| Year 2 | 365 |
| Year 3 | 422 |
| Year 4 | 479 |
| Year 5 | 536 |

## 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 that a waiting list for waiver services becomes necessary, the following entry criteria will be determined based upon date of application for services and according to the following order of priority:
1. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community OR Individuals who are at imminent risk of nursing home placement. Individuals who currently reside in the community and are at imminent risk of nursing facility placement within 24-72 hours or less.
2. Individuals who are in the community but can wait more than 72 hours for home and community-based services.

## Appendix B: 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **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)**

- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **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*:

- [x] **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: [ ]

**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 local Area Agency on Aging (AAA) Assessors conduct the initial level of care evaluations for individuals referred for waiver services. In addition a physician (M.D or D.O) completes the physician certification form which indicates the physician's diagnosis and level of care recommendation.

The AAA Assessors also conduct the annual reevaluations for participants that are already enrolled in the waiver. In addition, AAA Assessors are required to conduct reevaluations more frequently, if needed, when there are changes in a participant's functioning and/or needs.

**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 must meet the following qualifications:

1. One year of experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences OR
2. Two years of case work experience including one year of experience performing assessments of client's functional ability to determine the need for institutional or community based services and a bachelor's degree which include or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology or other elated social sciences OR
3. One year assessment experience and a bachelor's degree with social welfare major OR
4. Any equivalent combination of experience or training including successful completion of 12 semester credit hours of college level courses in sociology, social welfare, psychology, gerontology or other related social sciences. One year of case work experience in the AAA system may be substituted for one year assessment experience.

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

Physicians must be licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code.

**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.

An individual is Nursing Facility Clinically Eligible (NFCE) if he or she needs the level of care provided in a nursing facility.

Under Federal and State law and regulations, which identify the level of care provided in a nursing facility, a consumer should be considered NFCE if:

1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; and
2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board; and
3. A physician certifies that the individual is NFCE; and
4. The care and services are either

a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or

b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

The level of care determination is made using the Level of Care Assessment tool (LOCA) and the physician certification form which indicates the physician's diagnosis and level of care recommendation.

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: OLTL uses the following process to determine an individual's initial level of care:
• The participant first applies for Aging Waiver services through the local AAA.
• The AAA assists the participant with obtaining a completed physician certification form from the participant's physician (M.D. or D.O.)
• A physician completes the physician certification form indicating the physician's diagnosis and level of care recommendation.
• The AAA assessor visits the participant and uses the LOCA form to identify information regarding the participant's medical status, recent hospitalization, and functional ability (ADLs and IADLs). The same level of care tool, the LOCA, is used in all 67 counties for all individuals entering the waiver, and is the same tool used to determine institutional LOC.
• The AAA follows the status of the level of care determination process and assists with any required communication between the participant and the participant's physician.
• The AAA is responsible for making the final level of care evaluation decision subject to OLTL oversight.

Annual Reevaluation: OLTL uses the following process for the annual reevaluation of current participants:
• The AAA is responsible for completion of the annual reevaluation of the level of care.
• The AAA assessor visits the participant and uses the LOCA form to identify information regarding the participant's medical status, recent hospitalization, and functional ability (ADLs and IADLs).
• The AAA is responsible for making the final level of care reevaluation eligibility decision.

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

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

*Specify the other schedule:*

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

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

*Specify the qualifications:*

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

On an annual basis from the date the initial evaluation is completed, the AAA Assessor will meet with the participant in their home to reassess the participant's need for waiver services and complete the LOCA form. The AAA Assessor will be alerted to the Level of Care anniversary date through an automated notice from the Social Assistance Management System (SAMS). In addition, each AAA maintains its own tickler system to complete timely reevaluations and maintain consistency in service. AAA Assessors are required to conduct reevaluations more frequently, if needed, when there are changes in a participant's functioning and/or needs.

After the reevaluation is completed, the AAA Assessor enters the reevaluation information into SAMS. Reevaluation documentation is also maintained in the participant's file which is subject to review during OLTL annual monitoring visits.

AAA supervisory staff is responsible for monitoring reevaluation schedules monthly. OLTL monitors the timeliness of reevaluations through data extracts of the SAMS data system, through OLTL biennial provider monitoring visits and the retrospective service plan review process as described in the Quality Improvement section of Appendix D.

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:

Documentation of the participant's initial level of care determination and reevaluations are electronically maintained in the SAMS.

In addition, Service Coordinators maintain copies of evaluations and reevaluation in the participant's file located at the Service Coordination Entity.

## 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 new enrollees who have an initial level of care determination that adhered to timeliness and specification prior to receipt of waiver services Numerator: Total number of all initial LOC determinations that adhered to timeliness and specification prior to receipt of 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***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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: Total number of annual LOC reevaluations, that adhered to timeliness and specifications Denominator: Total number of waiver participants reviewed**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval =95% +/- 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| | |
|---|---|
| | |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Level of Care Sub-assurances are monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. The Bureau of Quality & Provider Management is responsible for review and analysis of the report information. Reports are received from case management systems and from a compilation of the results of retrospective service plan reviews. The LOC Assurance Liaison, within OLTL's BQPM, regularly reviews reports on a semi-annual basis regarding the completion of initial level of care prior to the receipt of waiver services. Quarterly reports are reviewed for compliance with waiver standards with processes and instruments for initial LOC. Monthly reports from the Service Plan retrospective review database are reviewed by the LOC Liaison regarding the timeliness of LOC reevaluations. See Appendix D for more information about retrospective service plan reviews and Appendix H for more information about Assurance Liaisons.

Additional information on the Bureau of Quality & Provider Management (BQPM) can be found in Appendix H.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the BQPM's review of LOC data in the case management or Retrospective Service Plan Review tracking systems identifies non-compliance regarding the timeliness or specifications of initial or annual LOC reassessments, a Quality Improvement Plan (QIP) is requested from BPO. More information on QIPs can be found in Appendix H.

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix 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

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

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility or community resident applies for Aging Waiver services and the participant is determined to likely require Nursing Facility level of care, the individual will be:

• Informed by the Area AAA of all available home and community-based service delivery alternatives, including the Living Independence for the Elderly (LIFE) program; and,

• Given the choice of receiving Nursing Facility institutional services, waiver services, LIFE program services where available, or no services.

Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the AAA or IEB where applicable, and ongoing by their Service Coordinator, of their right to choose between receiving community services in the waiver, the LIFE program where available, Nursing Facility services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form during the initial enrollment process and at time of the annual reevaluation. Documentation is made in the participant's file that the form was completed; completed forms are maintained in the participant's file.

Participant Freedom of Choice of Providers

The AAA and IEB are responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination agencies, and documenting the participant's choice of Service Coordinator on the OLTL Service Provider Choice Form. In addition, the AAA and IEB are responsible for educating participants of their right to choose from any qualified provider, their right to self-direct some or all of their services, and that they have the right to change providers at any time. The AAA and IEB will give each participant information about the Services and Supports Directory - a web-based listing of all qualified and enrolled waiver providers. The information contained in the Services and Supports Directory will also be made available in a non-web-based format, as necessary or when requested. Notation is made in the participant's record of receipt of the OLTL Service Provider Choice Form; completed forms are maintained in the participant's file with the selected Service Coordination Entity. OLTL monitors participant receipt of forms as part of its biennial review of providers.

The Service Coordination Entity is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial the Individual Service Plan (ISP), at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination Entity is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed, completed and signed the form. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination Entity. OLTL monitors participant receipt of the forms as part of its biennial provider reviews.

**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 OLTL Freedom of Choice and OLTL Service Provider Choice forms in the participant's record located at the Service Coordination Entity.

## 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 be made available, at no charge, to individuals who are deaf or hard of hearing.

All providers are required to have and implement policies and procedures for participants with limited English proficiency to ensure

meaningful access to language services as required by 55 Pa. Code Chapter 52. In addition, OLTL's requires AAAs to provide enrollment documents as well as language assistance available upon request, at no charge. Sign language services must also be made available, at no charge, to individuals who are deaf or hard of hearing.

Providers are required to provide a copy of their LEP policies and procedures to OLTL prior to enrollment as an HCBS waiver provider. In addition, as part of the monitoring reviews conducted by QMET, documentation of the LEP policies and procedures are reviewed. Corrective action plans are developed if the documentation cannot verified.

OLTL has also designated an LEP Coordinator to monitor any complaints from providers, participants, etc. relating to the lack of LEP services. Follow-ups are conducted to ensure that the necessary services are received.

## 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 Services | |
| Statutory Service | Personal Assistance Services | |
| Statutory Service | Respite | |
| Statutory Service | Service Coordination | |
| Extended State Plan Service | Home Health Services | |
| Other Service | Accessibility Adaptations, Equipment, Technology and Medical Supplies | |
| Other Service | Assistive Technology | |
| Other Service | Community Transition Services | |
| Other Service | Home Adaptations | |
| Other Service | Home Delivered Meals | |
| Other Service | Non-Medical Transportation | |
| Other Service | Participant-Directed Community Supports | |
| Other Service | Participant-Directed Goods and Services | |
| Other Service | Personal Emergency Response Service (PERS) | |
| Other Service | Specialized Medical Equipment and Supplies | |
| Other Service | TeleCare | |
| Other Service | Therapeutic and Counseling Services | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

**Alternate Service Title (if any):**

Adult Daily Living Services

**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 the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.
This service will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan.
Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant.
Adult Daily Living includes two components:
• Basic Adult Daily Living services
• Enhanced Adult Daily Living services.
Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per Subchapter A, and 11.123 Core Services, the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center.
In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:
• Nursing Requirement: The Enhanced Adult Daily Living provider shall directly provide, contract for, or otherwise arrange for nursing services. In addition to the requirements found in the Older Adult Daily Living Center (OADLC) Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the participant's service plan, with the corresponding follow-ups being made with the participant, family, or physician.
• Staff to Participant Ratio: Staffing of OADLC providing Enhanced services will be at a staff to participant ratio of 1:5.
• Operating Hours: To be eligible for the minimum rate associated with Enhanced Services, the OADLC must be open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday. (If open on a Saturday or Sunday the eleven hour requirement is not in effect for the weekend days of operation.)
• The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
• Enhanced Adult Daily Living services can be provided as either a full day or a half day.
• Adult Daily Living providers that are certified as Enhanced receive the Enhanced full day or Enhanced half day rate for all participants attending the Enhanced center.
As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Adult Daily Living services may only be funded through the waiver when the services are not covered by the State Plan, or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan, or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

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

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | 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 Services**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
PA Department of Aging/OLTL

**Frequency of Verification:**
Aging – Annually
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:**

Personal Care

**Alternate Service Title (if any):**

Personal Assistance Services

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 08 Home-Based Services | 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 safety of the participant.

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

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

• Care to assist with activities of daily living activities (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the participant to perform a task and providing supervision to assist a participant who cannot be safely left alone.

• Health maintenance activities provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements.

• Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the participant.

• Assistance and implementation of prescribed therapies.

• Overnight Personal Assistance Services to provide intermittent or ongoing awake, overnight assistance to a participant in their home for up to eight hours. Overnight Personal Assistance Services require awake staff.

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

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

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

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

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

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

transportation under the waiver.

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

Personal Assistance Services cannot be provided simultaneously with Home Health Aide, Respite, Participant-Directed Community Supports or Participant-Directed Goods and Services. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

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

## 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;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Be 18 years of age or older;
• Possess basic math, reading, and writing skills;
• Possess a valid Social Security number;
• Submit to a criminal record check;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Have the required skills to perform Personal Assistance Services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan; and
• Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.

**Verification of Provider Qualifications**

**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: 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;
• Comply with Department standards, regulations, and policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
• Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs; and
• Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for agencies must meet the following standards::
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
OLTL/PA 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: 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:**

**Service:**

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 09 Caregiver Support | 09011 respite, out-of-home |
| **Category 2:** | **Sub-Category 2:** |
| 09 Caregiver Support | 09012 respite, in-home |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope)*:
Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Federal and state financial participation through the waivers is limited to: 1) Services provided for individuals in their own home, or the home of relative, friend, or other family, or 2) Services provided in a Medicaid certified Nursing Facility. Room and board costs associated with Respite Services that are provided in a facility approved (licensed or accredited) by the state that is not a private residence are reimbursable. Respite Services furnished in a participant's home are provided in quarter hour units. Respite Services may also be provided in a long-term care facility on a per diem basis. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

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

Room and board costs are excluded from Respite Services when the service is provided in a setting that is not facility-based and approved by the state.

Individuals are authorized for up to 14 consecutive days in an institutional facility. However, this may be increased up to 29 consecutive days, based on need and with the prior approval of the State Medicaid Agency program office.

Medication management provided to participants receiving Respite Services in a Medicaid certified Nursing Facility is subject to the provisions of Appendix G-3.

In-home Respite Services cannot be provided simultaneously with Home Health Aide Services, Personal Assistance Services, Participant-Directed Community Supports or Participant-Directed Goods and Services.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Care Agency |
| Agency | Medicaid Certified Nursing Facility |
| Agency | Home Health 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:**
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;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
• Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for agencies must meet the following standards:
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
**Verification of Provider Qualifications**
**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:**
Agency

**Provider Type:**
Medicaid Certified Nursing Facility
**Provider Qualifications**
**License** *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart A Chapter 51, and Subpart B. Chapter 201.
**Certificate** *(specify):*
Certification as required by specific profession or discipline, per 42CFR Part 484
**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
PA Department of Health
**Frequency of Verification:**
Annually by the Department of Health

## 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 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 qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Be supervised by a registered nurse;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).
**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

**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 qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Be 18 years of age or older;
• Possess basic math, reading, and writing skills;
• Possess a valid Social Security number;
• Submit to a criminal record check;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Have the required skills to perform Personal Assistance Services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan; and
• Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Fiscal Employer Agent/OLTL

**Frequency of Verification:**
F/EA - At time of hire
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:**

**Service:**
Case Management

**Alternate Service Title (if any):**
Service Coordination

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 01 Case Management | 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. Service Coordination includes the primary functions of providing information to participants and facilitating access, locating, coordinating and monitoring needed services and supports for waiver participants.
This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements, and as outlined in the participant's service plan.
In the performance of providing information to participants, the Service Coordinator will:
• Inform participants about the waiver, required needs assessments, the participant-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities.
• Inform participants on fair hearing rights and assist with fair hearing requests when needed and upon request.
In the performance of facilitating access to needed services and supports, the Service Coordinator will:
• Collect additional necessary information, including, at a minimum, participant preferences, strengths and goals to inform the development of the participant-centered service plan.
• Assist the participant and his/her service planning team in identifying and choosing willing and qualified providers.
• Coordinate efforts and prompt the participant to ensure the completion of activities necessary to maintain waiver eligibility.
In the performance of the coordinating function, the Service Coordinator will:
• Coordinate efforts in accordance with Department requirements and prompt the participant to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan.
• Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
– Include people chosen by the participant for service plan meetings, review assessments, including discussion of needs, to gain understanding of the participant's preferences, suggestions for services and other activities key to ensure a participant-centered service plan.
– Provide necessary information and support to ensure that the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
– Be timely and occur at times and locations of convenience to the participant.
– Reflect cultural considerations of the participant.
– Include strategies for solving conflict or disagreement within the process.
– Offer choices to the participant regarding the services and supports they receive and the providers who may render them.
– Inform participants of the method to request updates to the service plan.
– Ensure and document the participant's participation in the development of the service plan.
• Develop and update the service plan in accordance with Appendix D, based upon the standardized needs assessment and participant-centered planning process annually, or more frequently as needed.
• Explore coverage of services to address participant identified needs through other sources, including services provided under the State Plan, Medicare and/or private insurance or other community resources. These resources shall be used until the plan limitations have been reached or a determination of non-coverage has been established and prior to any service's inclusion in the service plan, in accordance with Department standards.
• Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the participant, to ensure seamless coordination between physical, behavioral and support services.
• Coordinate with providers and potential providers of services to ensure seamless service access and delivery.
• Coordinate with the participant's family, friends and other community members to cultivate the participant's natural support network, to the extent that the participant (adult) has provided permission for such coordination.
In the performance of the monitoring function, the Service Coordinator will:
• Ensure that services are furnished in accordance with the ISP.
• Ensure that services meet participant needs.
• Monitor the health, welfare and safety of the participant and service plan implementation through regular contacts (monitoring visits with the participant, paid and unpaid caregivers and others) at a minimum frequency as required by the Department.
• Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare and safety of the participant in accordance with Appendix G.
• Monitor the effectiveness of back-up plans.
• Review provider documentation of service provision and monitor participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes.
• Through the service plan monitoring process, solicit input from participant and/or family, as appropriate, related to satisfaction with services.
• Arrange for modifications in services and service delivery, as necessary, to address the needs of the participant, consistent with an assessment of need and Department requirements, and modify the service plan accordingly.

• Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and participant rights.
• Participate in any Department identified activities related to quality oversight.
Service Coordination includes functions necessary to facilitate community transition for participants who received Medicaid-funded institutional services (i.e. Nursing Facilities and Institution for Mental Disease) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Service Coordination activities for participants leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community.
Service Coordination entities must use an information system as approved and required by the Department to maintain case records in accordance with Department requirements.
Services must be delivered in a manner that supports the participant's communication needs, including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Service Coordination is limited to 144 units over a 12-month period. However, in order to meet the varying needs of individuals for service coordination services, this service limitation may be waived when reviewed and approved by OLTL.

The following activities are excluded from Service Coordination as a billable waiver service:
• Outreach or eligibility activities (other than transition services) before participant enrollment in the waiver.
• Travel time incurred by the Service Coordinator may not be billed as a discrete unit of service.
• Services that constitute the administration of another program such as protective services, parole and probation functions, legal services, and public guardianship.
• Representative payee functions.
• Other activities identified by the Department.
Service Coordination must be conflict free and may only be provided by agencies and individuals employed by agencies who are not:
• Related by blood or marriage to the participant or to any paid service provider of the participant
• Financially or legally responsible for the participant.
• Empowered to make financial or health-related decisions on behalf of the participant.
• Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant.
• Individuals employed by agencies paid to render direct or indirect services (as defined by the Department) to the participant, or an employee of an agency that is paid to render direct or indirect services to the participant.
Claims for costs incurred on behalf of participants transitioning from an institutional setting may only be paid after the transition to the community.
Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Meet the conflict free requirements pursuant to 55 PA Code, Chapter 52, §52.28;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs;
• Comply with and meet all standards as applied through each phase of the standard, annual Department performed monitoring process;
• Ensure 24-hour access to Service Coordination personnel (via direct employees or a contract) for response to emergency situations that are related to the Service Coordination service or other waiver services;
• Sufficient professional staff to perform the needed assessment/reevaluation, service coordination and support activities; and
• Registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement.
Service Coordinators must meet the following:
• Be at least 18 years of age;
• Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Service Coordination Supervisors must meet the following:
• Be at least 18 years of age;
• Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**
**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:**
Extended State Plan Service
**Service Title:**
Home Health Services

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

| | |
|---|---|
| 05 Nursing | 05020 skilled nursing |
| **Category 2:** | **Sub-Category 2:** |
| | 11080 occupational therapy |
| **Category 3:** | **Sub-Category 3:** |
| 11 Other Health and Therapeutic Services | 11090 physical therapy |
| **Category 4:** | **Sub-Category 4:** |
| 11 Other Health and Therapeutic Services | 11100 speech, hearing, and language therapy |

**Service Definition** *(Scope):*
Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. Home Health Aide Services
Home Health Aide services are direct services prescribed by a physician in addition to any services furnished under the State Plan that are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The physician's order must be obtained every sixty (60) days for continuation of service. The home health aide provider is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan.
Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist

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

Nursing services must be performed by a Registered Nurse or Licensed Practical Nurse. 49 PA Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing, "Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

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

• Short-term or Intermittent Nursing — Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a service plan year and are over and above services available to the participant through the State Plan
• Long-term or Continuous Nursing — Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per service plan year, are provided on a regular basis and are over and above services available to the participant through the State Plan
The nurse is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan

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

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

take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Physical Therapy services authorized in the service plan.

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

4. Occupational Therapy
Occupational Therapy services are direct services prescribed by a physician, in addition to any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.
Occupational Therapy services must address an assessed need documented in the participant's service plan. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Occupational Therapy services authorized in the service plan.

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

5. Speech and Language Therapy
Speech and Language Therapy services are direct services prescribed by a physician, in addition to any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.
Speech and Language Therapy services must address an assessed need as documented in the participant's service plan. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Speech and Language Therapy services authorized in the service plan.

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

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Home Health Services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance.
Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.
Home Health Care Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.
Service is limited to needs determined during the assessment and identified in the participant's service plan.
The most appropriate level of staffing, as determined by the assessment, must be used for a task.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's

service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | Occupational Therapist or Assistant (agency affiliated or individual) |
| Agency | Out-Patient or Community-Based Rehabilitation Agency |
| Individual | Physical Therapist or Assistant (agency affiliated or individual) |
| Individual | Speech Therapist (agency affiliated or individual) |
| Agency | Home Health Agency |

## 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 qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

**Verification of Provider Qualifications**

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

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

**Verification of Provider Qualifications**

**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:**
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 qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

**Verification of Provider Qualifications**

**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:**
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 qualifications, including 55 PA Code Chapter 52;

• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Be supervised by a registered nurse;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

**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: 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 AGING WAIVER EFFECTIVE JULY 1, 2015. PLEASE SEE HOME ADAPTATIONS; ASSISTIVE TECHNOLOGY; OR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES.

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Items shall be specific to a participant's individual needs. Training to utilize adaptations, modifications and devices is included in the purchase as applicable. This service includes the following components:

• Accessibility adaptations to the participant's home, apartment, or other living arrangement in which the participant resides such as the participant's family's home, or the participant's friend's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and are permanently attached to an individual's fixed environment. This service includes selecting, designing, customizing or replacing accessibility adaptations; evaluating the construction, provision or installation of accessibility adaptations during the adaptation and re-adaptation process; and providing post-installation visual inspections and ensuring that participants accept and can use their accessibility adaptations. Such adaptations include:
o the installation of ramps and railings, the installation of specialized electric and plumbing systems that are necessary to ensure the health and welfare of the participant and contribute to the participant's independence in everyday life, environmental and climate control units, automatic door openers and locks, speaker phones and intercom systems, special lighting devices, over-the-bed tables, stair glider, widening doorways and hallways, non-skid mats, stair strips and runners, wall protection strips and wall runners for wheelchairs, light switch adaptations or extensions, door knob extensions, smoke/fire alarm system adaptations;
o handrails and grab bars – such as those required in a bathroom, or in other areas of the home, modification of bathroom facilities, bath bench and bath lifts, stall adaptations – including roll-in showers and fixtures, fixture adaptations for sinks, showers or stoves, kitchen counter and cabinet modifications for participants who use wheelchairs; Rearrangement and new installation of plumbing, drains, electricity, and floor plans to permit least-cost, beneficial home modifications and assistive technology.
o rented property modifications must meet the following:
• there is a reasonable expectation that the participant will continue to live in the home;
• permission is secured from the property owner for the adaptation;
• the adaptation is not the responsibility of the landlord in their maintenance and oversight of the property; and
• the landlord will not increase the rent because of the adaptation.
o other modifications approved by OLTL as a part of an individual's service plan
All items shall meet applicable standards of manufacture, design and installation. Services will be provided in accordance with applicable federal, state and local building codes. Home Adaptations must be an item or modification that the family would not be expected to provide to a family member without a disability or specialized needs.
• Specialized medical equipment, technology and supplies include:
o devices, controls, or appliances, specified in the service plan, that enable participants to increase, maintain, or improve their ability to perform activities of daily living;
o devices, controls, or appliances that enable, increase, maintain, or improve the ability of the participant to perceive, control, or communicate with the environment in which they live;
o items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
o such other durable and non-durable medical equipment not available under the State Medicaid Plan that is necessary to address participant functional capabilities; and
o necessary medical supplies not available under the State Medicaid Plan.
All items shall meet applicable standards of manufacture, design and installation.
• Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology service includes:
o the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
o services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
o services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
o training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
o training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.
All items shall meet the applicable standards of manufacture, design and installation.

The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACCESSIBILITY ADAPTATIONS, EQUIPMENT, TECHNOLOGY AND MEDICAL SUPPLIES IS NO LONGER A SERVICE IN THE AGING WAIVER EFFECTIVE JULY 1, 2015. PLEASE SEE HOME ADAPTATIONS; ASSISTIVE TECHNOLOGY; OR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES.

Participants must access durable medical equipment and supplies and medical supplies through the Medicaid State Plan before seeking services through the Aging Waiver. The accessibility adaptations, equipment, technology and medical supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Medicaid Plan and exclude those items that are not of direct medical or remedial benefit to the participant. Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached prior to requesting services in the service plan.

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

Any specialized medical equipment, technology or supplies that exceed $500 requires a review by the State Medicaid Agency program office.

Accessibility Adaptations improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant are excluded. Home repairs are not included under this service definition. Home repairs include, but are not limited to roof repair/replacement, furnace/air conditioning maintenance and repair, general plumbing and electrical repair/replacement, driveway repair/maintenance. Repairs that are exclusively cosmetic are not covered. Adaptations that add to the total square footage of the home are excluded from this service except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Home Adaptations included in the service plan and begun while the person was institutionalized are not considered complete and may not be billed until the date the participant leaves the institution and enters the waiver.

Home adaptations must be obtained at the lowest cost. Any home adaptation that exceeds $6,000 requires prior authorization by OLTL.

Building a new room is excluded. Accessibility Adaptations cannot be provided in residential settings that are owned and operated by the provider

Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the Department when an independent evaluation specifies that the item is primarily used for a participant's specific therapeutic purpose and serves as a less costly alternative than other suitable devices and alternative methods.

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

This service does not include TeleCare Services.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Pharmacy |
| Individual | Contractor |
| 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:**

Agency

**Provider Type:**
Pharmacy
**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, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).;, and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
OHCDS, OLTL
**Frequency of Verification:**
At time of service
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: 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):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply;
• Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license; and

• Compliance with the Pennsylvania Home Improvement Consumer Protection Act and other applicable standards.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS, OLTL

**Frequency of Verification:**
At time of service
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: 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)*:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker’s Compensation insurance in accordance with State statute and in accordance with Department policies; and
• Have Commercial General Liability insurance.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS, OLTL

**Frequency of Verification:**
At time of service
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:**

Assistive Technology

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
| **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) and determined necessary in accordance with the participant's assessment. The service is intended to ensure the health, welfare and safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities.

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

Assistive Technology is limited to:

• Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for participants

• Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device

• Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings

• Training or technical assistance for the participant, paid caregiver and unpaid caregiver

• An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment

• Extended warranties

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

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

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

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

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

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

This service excludes those items that are not of direct medical or remedial benefit to the participant. Assistive Technology

devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the OLTL when an independent evaluation specifies that the item is primarily used for a participant's specific therapeutic purpose and serves as a less costly alternative than other suitable devices and alternative methods.
The following are specifically excluded from this service definition
• Recreational items
• Items that do not provide direct remedial benefit or improve the participant's ability to communicate with others
Depending on the type of technology, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; physical therapist; or other certified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Independent evaluations conducted by a certified professional as defined in the provider qualifications for this service, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.
Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service..
This service does not include TeleCare services. Data plans are excluded from coverage.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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: 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 qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
• Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professional must be a graduate of a Department approved Rehabilitative Sciences program that is Certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or a Rehabilitative Sciences degree with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities.

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professional must be a graduate of a Department approved Rehabilitative Sciences program that is Certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or a Rehabilitative Sciences degree with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities.
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

**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: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**

**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 qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (A company that the provider secures the item(s) from can be located anywhere)
• Adhere to all applicable local and State codes
• Have Commercial General Liability Insurance
• Have Workers Compensation Insurance, in accordance with State statute

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS

**Frequency of Verification:**
Upon purchase

## 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: | Sub-Category 1: |
|---|---|
| 16 Community Transition Services | 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 to enable the participant to integrate more fully into the community and to ensure health, welfare and safety of the participant.

Community Transition Services may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:
• Equipment, essential furnishings and initial supplies. Examples—e.g. household products, dishes, chairs, tables;
• Moving Expenses;
• Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement;
• Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating;
• Items for personal and environmental health and welfare (Example personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.)
The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
• Community Transition Services are furnished only to the extent that they are reasonable and necessary, as determined through the ISP development process; clearly identified in the service plan and the participant is unable to meet such expense; or when the service cannot be obtained from other resources
• Expenditures may not include ongoing payment for rent or mortgage expenses.
• Community Transition Services do not include food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.
• Community Transition Services are limited to the purchase of the specific items to facilitate transition and not the supports or activities provided to obtain the items.
• Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Vendor |
|---|---|
| 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:**
Individual
**Provider Type:**
Independent Vendor
**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 qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
OHCDS
OLTL
**Frequency of Verification:**
OHCDS - 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: 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 qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS
OLTL

**Frequency of Verification:**
OHCDS - 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: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 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 health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. This includes primary

egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home.
Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations.
Adaptations to a household are limited to the following:
• Ramps from street, sidewalk or house
• Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the participant
• Vertical lifts
• Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving a participant with a disability from one location to another
• Handrails and grab-bars in and around the home
• Accessible alerting systems for smoke/fire/carbon monoxide for participants with sensory impairments
• Outside railing to safely access the home
• Widened doorways, landings and hallways
• Swing-clear and expandable offset door hinges
• Flush entries and leveled thresholds
• Slip resistant flooring
• Kitchen counter, sink and other cabinet modifications (including brackets for appliances)
• Bathroom adaptations for bathing, showering, toileting and personal care needs
• Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely
• Raised electrical switches and sockets
• Other adaptations, subject to OLTL approval, to address specific assessed needs as identified in the service plan
All adaptations to the home shall be provided in accordance with applicable building codes.
Home Adaptations shall meet standards of manufacture, design and installation.
Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs.
The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Home Adaptations may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Supports Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with OLTL requirements must be maintained in the participant's file by the Service Coordinator and updated with each authorization.
This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home Adaptations included in the service plan and begun while the person was institutionalized are not considered complete and may not be billed until the date the participant leaves the institution and enters the waiver.
Home adaptations must be obtained at the lowest cost.
Building a new room is excluded. Specialized Medical Equipment and Supplies is excluded.
Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom.
Materials and equipment must be based on the participant's need as documented in the ISP.
Rented property adaptations must meet the following:
• there is a reasonable expectation that the participant will continue to live in the home;
• written permission is secured from the property owner for the adaptation;
• the landlord will not increase the rent because of the adaptation.
• there is no expectation that waiver funds will be used to return the home to its original state.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable.
• All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply
• Organizations must have capacity to provide 24-hour coverage by trained professionals, 365 days/year
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Be a Licensed Contractor
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS or OLTL

**Frequency of Verification:**
OHCDS – 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 qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable.
• All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply
• Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license
• Compliance with the Pennsylvania Home Improvement Consumer Protection Act and other applicable standards
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs, if applicable.
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
OHCDS or OLTL
**Frequency of Verification:**
OHCDS – 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:**
Home Delivered Meals

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | 06010 home delivered meals |
| **Category 2:** | **Sub-Category 2:** |
| | |

**Category 3:** **Sub-Category 3:**

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

**Service Definition** *(Scope):*
The Home Delivered Meals service provides meals that meet at least one-third of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant. Participants may receive more than one meal per day, but they cannot receive meals that constitute a "full nutritional regimen" (three meals per day).
All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:
• May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods
• Can either be a hot, cold, frozen or shelf-stable meal
Meals may be delivered as singles or multiples, as long as the number of planned daily meals does not exceed two meals per day and the participant has appropriate storage and support to ensure that meals last as intended.
All menus must be approved and signed by an approved dietitian.
The frequency and duration of Home Delivered Meals are based upon the participant's needs, as identified and documented in the participant's service plan.

The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Home Delivered Meals are provided only during those times when neither the participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision.
Meals provided as part of this service shall not constitute a full nutritional regimen (three meals per day).
Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.
Participants eligible for non-waiver nutritional services, including the Older Americans Act, will access those services first.
This service should supplement and not supplant resources to which the participant may be entitled including the Supplemental Nutritional Assistance Program (SNAP).
This service does not include nutritional assessment, education or counseling, but may be used in conjunction with a nutritional service offered through the waiver when needed for the participant.
Area Agencies on Aging and service providers may not solicit donations for Home Delivered Meals from waiver participants.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Delivered Meals Vendors |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Home Delivered Meals Vendors
**Provider Qualifications**
**License** *(specify):*

N/A
**Certificate** *(specify):*
N/A
**Other Standard** *(specify):*
• Safe food handling, preparation and transportation standards conform with Title 7 PA Code Chapter 46, Food Code

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS/OLTL
**Frequency of Verification:**
Annually OHCDS verifies provider qualifications prior to service approval; annually thereafter
OLTL monitors OHCDS 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:**

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: | Sub-Category 1: |
|---|---|
| 15 Non-Medical Transportation | 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 required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must be tied to a specific objective identified on the participant's service plan.

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

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Medical Assistance Transportation Program (MATP) services will be used for obtaining State Plan services. The participant's service plan must document the need for those Non-medical Transportation services that are not covered under the Medical Assistance Transportation Program.

Non-medical Transportation services may only be authorized on the service plan after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the participant, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the participant or another individual when driving the participant's

vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs.

Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Transportation Agency, Public Transit Authority |
| Individual | Individual Driver |

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OLTL
OHCDS

**Frequency of Verification:**

OHCDS verifies provider qualifications prior to service approval; annually thereafter
OLTL monitors 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:**
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;
• Must have appropriate insurance coverage ($100,000/$300,000 bodily injury);
• Have automobile insurance for all automobiles used to provide the Transportation service;
• Vehicles must be registered with the PA Department of Transportation;
• Receive a physical examination (including a vision test) at the time of hire and at least every 2 years; and
• Be willing to provide door-to-door services.
**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:**
Participant-Directed Community Supports

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08030 personal care |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

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

**Service Definition** *(Scope)*:
Participant-Directed Community Supports will be offered to participants choosing budget authority under the Services My Way model. Participant-Directed Community Supports are specified by the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant. The participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the participant.
Services include assisting the participant with the following:
• Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living;
• Health maintenance activities such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities;
• Improving and maintaining mobility and physical functioning;
• Maintaining health and personal safety;
• Carrying out household chores such as shopping, laundry, cleaning and seasonal chores;
• Preparation of meals and snacks;
• Accessing and using transportation (If providing transportation, the support services worker must have a valid driver's license and liability coverage as verified by the F/EA); and
• Participating in community experiences and activities.

Supports will be available to assist the participant in performing employer-related duties and responsibilities through the Fiscal/Employer Agent (F/EA) and Service Coordinator.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Participant-Directed Community Support services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services and Participant-Directed Goods and Services.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual Support Services Worker |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Participant-Directed Community Supports**

**Provider Category:**
Individual

**Provider Type:**
Individual Support Services 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 qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be at least 18 years of age;
• Possess a valid Social Security number;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• When required by the participant, the individual must be able to demonstrate the capability to perform health maintenance activities or receive necessary training

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The participant and Fiscal/Employer Agent

**Frequency of Verification:**
•• At time of selection of the individual worker to be hired;
• F/EA will verify provider qualifications are met during the provider employment process and will enter into a provider agreement with each provider on behalf of the State Medicaid agency

## 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:**
Participant-Directed Goods and Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17010 goods and services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
This service is only available through the Services My Way (budget authority) participant-directed model.

Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan. These items must address an identified need in the participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:
• Decrease the need for other Medicaid services;

• Promote or maintain inclusion in the community;
• Promote the independence of the participant;
• Increase the individual's health and safety in the home environment,
• Develop or maintain personal, social, physical or work-related skills;
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support; or
• Fulfill a medical, social or functional need as identified in the participant's individual service plan.

Participant-directed goods and services are purchased from the participant's Individual Spending Plan.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Participant-directed Goods and Services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

Participant-Direct Goods and Services does not include personal items and services not related to the disability, groceries, rent or mortgage payments, entertainment activities, or utility payments.

Participant-Directed Goods and Services may not be provided at the same time as Home Health Aide Services, Personal Assistance Services, and Participant-Directed Community Supports.

Participant-directed Goods and Services are limited to instances when the participant does not have personal funds to purchase the item or service and the item or service is not available through another source. Services are limited to participants that are utilizing Budget Authority for participant-directed services.

Experimental or prohibited treatments are excluded.

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

- [x] **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 | Agency |
| Individual | Individual |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Participant-Directed Goods and Services**

**Provider Category:**
Agency
**Provider Type:**
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 qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department

policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavior needs
• Vendor/Fiscal Employer must enter into a Medicaid Provider Agreement with each provider on behalf of the State Medicaid Agency; and
• Providers must meet applicable State and local regulations and/or Medicaid provider qualifications for the type of service the provider/supplier is providing as written in the participant's service plan.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Fiscal/Employer Agent
**Frequency of Verification:**
•• At time of enrollment and as necessary
• The F/EA will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the State Medicaid Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Participant-Directed Goods and Services**

**Provider Category:**
Individual
**Provider Type:**
Individual
**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 qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be at least 18 years of age;
• Possess a valid Social Security number;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• When required by the participant, the individual must be able to demonstrate the capability to perform health maintenance activities or receive necessary training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Fiscal/Employer Agent
**Frequency of Verification:**
•• At time of enrollment and as necessary
• The F/EA will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the State Medicaid Agency

## 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 Service (PERS)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 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 signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year.

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

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

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

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

The Service Coordinators must assure that coverage of services provided under a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization.

Installation is covered one time per residential site.

Stand alone smoke detectors will not be billed under PERS.

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 and Supply Company |
| Agency | Home Health Agency |
| Agency | Vendors of Personal Emergency Response Systems |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Emergency Response Service (PERS)**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS/OLTL

**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 Service (PERS)**

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

**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 qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• All PERS installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply, including any applicable business license; and
• Organization must have capacity to provide 24-hour coverage by trained professionals, 365 days/year.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications,

including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
OHCDS/OLTL

**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:**

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: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
| **Category 2:** | **Sub-Category 2:** |
| 14 Equipment, Technology, and Modifications | 14032 supplies |
| **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, welfare and safety of the participant and enable the participant to function in the home and community with greater independence. This service is intended to enable participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the participant's service plan and determined necessary in accordance with the participant's assessment.

Specialized Medical Equipment and Supplies includes:
• Devices, controls or appliances, specified in the service plan, that enable participants to increase, maintain or improve their ability to perform activities of daily living.
• Equipment repair and maintenance, unless covered by the manufacturer warranty
• Items that exceed the limits set for Medicaid State plan covered services
• Rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment and Supplies
Non-Covered Items:
• All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
• Items covered under third party payer liability
• Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's

disability
• Food, food supplements, food substitutes (including formulas), and thickening agents;
• Eyeglasses, frames, and lenses;
• Dentures
• Hearing Aids
• Any item labeled as experimental that has been denied by Medicare and/or Medicaid
• Recreational or exercise equipment and adaptive devices for such
All items shall meet applicable standards of manufacture, design and installation.
If the participant receives Speech, Occupational, or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Specialized Medical Equipment and Supplies, the Specialized Medical Equipment and Supplies must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Specialized Medical Equipment and Supplies may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

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

Specialized Medical Equipment and Supplies exclude Assistive Technology.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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

qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

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

**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:**
TeleCare

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | 11010 health monitoring |
| **Category 2:** | **Sub-Category 2:** |
| 11 Other Health and Therapeutic Services | 11030 medication assessment and/or management |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope)*:
TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary to enable the participant to promote independence and to ensure the health, welfare and safety of the participant and are provided pursuant to consumer choice. TeleCare includes: 1) Health Status Measuring and Monitoring TeleCare Service, 2) Activity and Sensor Monitoring TeleCare Service, and 3) Medication Dispensing and Monitoring TeleCare Services.

• Health Status Measuring and Monitoring TeleCare Services:
o uses wireless technology or a phone line, including electronic communication between the participant and healthcare provider focused on collecting health related data, i.e., vital signs information such as pulse/ox and blood pressure that assists the healthcare provider in assessing the participant's condition) and providing education and consultation;
o must be ordered by a primary physician, physician assistant, or nurse practitioner;
o includes installation, daily rental, daily monitoring and training of the participant, their representative and/or employees who have direct participant contact;
o monitoring service activities must be provided by trained and qualified home health staff in accordance with required provider qualifications; and
o have a system in place for notification of emergency events to designated individuals or entities.
• Activity and Sensor Monitoring TeleCare Service:
o employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively tracking participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature;
o includes installation, monthly rental, monthly monitoring, and training of employees who have direct participant contact; and
o ensures there is a system in place for notification of emergency events to designated individuals.
• Medication Dispensing and Monitoring TeleCare Service:
o assists participants by dispensing and monitoring medication compliance; and
o utilizes a remote monitoring system personally pre-programmed for each participant to dispense, monitor compliance and provide notification to the provider or family caregiver of missed doses or non-compliance with medication therapy.

All other medical equipment and supplies of value to the participant to maintain safety in the home can be purchased using "Specialized Medical Equipment and Supplies."

**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 TeleCare services when they meet eligibility criteria specified in the state's published TeleCare Services policy guidance, and the services are not covered under Medicare or other third party resources.

The Service Coordinator is responsible for verifying that third party limitations have been exhausted prior to funding services through the waiver. Documentation that the services are not available under another source of funding must be maintained in the individual's file and updated annually. The Service Coordinator, through the person-centered planning process, will ensure that the use of this service is in accordance with privacy considerations for the participant and is in accordance with the participant's preferences for service receipt.

If a participant only requires a medication dispenser unit and no monitoring services, the Medication Dispensing and Monitoring TeleCare Service will not be authorized under TeleCare. Medication dispensers without monitoring should be billed under "Specialized Medical Equipment and Supplies."

Medication Dispensing services cannot be provided at the same time as Home Health Care Aide Services, Nursing or in-home Respite Services.

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

**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 | Hospital |
| Agency | Home Health Agency |
| Agency | Durable Medical Equipment and Supply Company |
| Agency | Pharmacy |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: TeleCare**

**Provider Category:**

Agency

**Provider Type:**

Hospital

**Provider Qualifications**

**License** *(specify)*:

Licensed through the PA Department of Health, per 28 PA Code Subpart B

**Certificate** *(specify)*:

Certification as required by specific profession or discipline, per 42CFR Part 482

**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 qualifications, including 55 PA Code, Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;

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

**Verification of Provider Qualifications**

**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: TeleCare**

**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 42 CFR 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 qualifications, including 55 PA Code, Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker’s Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Meet provider requirements as specified in the TeleCare Services Directive;
• Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Be supervised by a registered nurse, as appropriate; and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**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: TeleCare**

**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 qualifications, including 55 PA Code, Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Meet provider requirements as specified in the TeleCare Services Directive;
• Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.

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

**Verification of Provider Qualifications**

**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: TeleCare**

**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 signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Meet provider requirements as specified in the TeleCare Services Directive;
• Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications,

including 55 PA Code, Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**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:** |
| 10 Other Mental Health and Behavioral Services | 10060 counseling |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

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

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

• Nutritional Consultation assists the participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant, caregiver and any providers in the implementation of the

plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home Health Agencies that employ licensed and registered dietitians may provide nutritional counseling.

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

Therapeutic and Counseling Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or a responsible third-party, such as Medicare or private insurance The Service Coordinator must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | Licensed Psychologist |
| Individual | Licensed Professional Counselor |
| Individual | Licensed Social Worker |
| Individual | Registered Dietitian or a Certified Nutrition Specialist |

## 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 Chapter 611 (Home Care Agencies and Home Care Registries)

**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;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
• Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for or contracted with agencies must meet the following standards:
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

**Verification of Provider Qualifications**

**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:**

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

**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:**

**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 qualifications;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
**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:**
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 qualifications;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
**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:**
Registered Dietitian or a 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 qualifications;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Title 49 PA Code Ch. 21 Subchapter G relates to the general provisions, licensure requirements and the responsibilities of the licensed dietician-nutritionist issued under sections 2.1(k) and 11(c) of the Professional Nursing Law (63 P. S. § 212(k) and 221(c).

**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: 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:*

- [x] **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, and the Older Adult Protective Services Act. Individuals choosing to self-direct their services have the right to employ a worker regardless of the outcome of the background check. Support service workers who are employed by waiver participants must have criminal history clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has a criminal record.

Criminal history clearances are obtained from the Pennsylvania State Police within 30 work days from the date that the employee/provider initiates services to the participant. The Pennsylvania State Police access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC) for this information; results are typically available within 1-2 business days. A Federal Bureau of Investigation (FBI) federal criminal history record is required for applicants who have resided in Pennsylvania for less than two years.

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

The Fiscal/Employer Agent (F/EA) is responsible for securing criminal history background checks for prospective support workers prior to hiring workers. The cost of conducting criminal history background checks is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to 1) document that the criminal history background check was conducted; 2) notify individuals of the results of the background check, and 3) document the individual's decision to employ a support worker with a criminal record and their acceptance of responsibility for their decision.

OLTL reviews provider personnel records as part of the biennial monitoring to ensure that criminal history checks are conducted and documented as referenced in the Quality Improvement section in this Appendix. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.

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 Public Welfare maintains a child abuse registry of individuals who have been named as a perpetrator of founded or indicated child abuse. A similar registry is not maintained for individuals who have been named as a perpetrator of founded or indicated elder abuse; these results are reported on the criminal history background check.

Written results of child abuse clearances are required for all Support Service workers providing services in homes where minor children reside. These clearances are obtained from the Office of Children, Youth and Families, DPW-Childline and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717)783-6211 within 30 work days from the date the provider initiates services to the participant. Support Service workers who are employed by waiver participants must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.

The home care/personal assistance agency is responsible for securing child abuse clearances for their employees. The agency must have a system in place to document that the child abuse clearance was conducted. In the interim of securing the written results of child abuse clearances, the provider of service will obtain written certification from the employee which confirms that the employee has not, within five (5) years immediately preceding the date of enrollment into the waiver program been named on a

central child abuse registry as being a perpetrator of founded or indicated child abuse.

The F/EA is responsible for securing child abuse clearances for prospective Support Service workers. The cost of conducting child abuse clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the child abuse clearance was conducted.

OLTL reviews provider personnel records as part of the biennial monitoring to ensure that child abuse clearances are conducted and documented as referenced in the Quality Improvement section in this Appendix. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.

## Appendix C: Participant Services

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

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

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

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

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

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

**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:
• The Aging Waiver will not pay for services furnished by a spouse.

• The Aging Waiver will not pay for services furnished by a participant's legal guardian.

• The Aging Waiver will not pay for services furnished by a Power of Attorney (POA) of a participant.

• The Aging Waiver will not pay for services furnished by a Representative Payee.

Aside from the exceptions noted above, there are no restrictions on the types of family members who may provide Personal Assistance Services.

Family members who provide Personal Assistance Services must meet the same provider qualification standards as Support Service workers who provide Personal Assistance Services to non-relatives. ISPs for individuals who receive more than 40 hours per week of services from one individual (family member or non-family member) will be reviewed and approved by OLTL. Service Coordinators will monitor the provision of services in accordance with OLTL established protocols.

OLTL will review participant records as part of the biennial monitoring to ensure that Service Coordinators have monitored the provision of services and documented their monitoring activities in accordance with OLTL protocols.

Participants that employ family members to provide Personal Assistance Services, like all providers, must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews authorized billable units through the Social Assistance Management System (SAMS). Reimbursement for services rendered is generated through the Provider Reimbursement Operations Management Information System (PROMISe).

Service delivery is monitored electronically through SAMS and PROMISe to provide reimbursement for services approved in the participant's ISP. The F/EA will not pay for services that are not documented as necessary on the ISP.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-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 a continuous open enrollment of providers and does not limit provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available upon request from the OLTL, and are also available to potential providers online through the DPW website http://www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm

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

## 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: Total number of new waiver providers meeting required licensure, and initial QP standards prior to service provision Denominator: Total number of new waiver 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| |
|---|
| ☐ **Continuously and Ongoing** |
| ☐ **Other** Specify: |

**Performance Measure:**
**QP-2: Number and percent of providers continuing to meet applicable licensure/certification, regulatory and applicable waiver standards following initial enrollment Numerator: Total number of providers continuing to meet applicable licensure and initial QP standards 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| | |
|---|---|
| | |

**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/non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision Numerator: Number of newly enrolled providers who meet requirednon-licensed/non-certified 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |

| | |
|---|---|
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**QP-6: Number and percent of non-licensed/non-certified providers who continue to meet waiver provider qualifications Numerator: Number of non-licensed/non-certified providers continuing to required licensure and initial 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***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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 meeting 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**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 of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal Representatives. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator.

The Quality Management Efficiency Teams (QMETs) monitor the HCBS Waiver providers on a biennial basis. The QMET utilizes a standardized monitoring tool for each monitoring, and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code and the provider requirements of the established, approved waivers. QMET also reviews if the provider has the appropriate licensure as required by the waiver. QMET reviews each provider at a 95% accuracy rating for each waiver in which the provider is enrolled.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
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 certified provider is required to submit written documentation that it meets regulatory and initial qualified waiver requirements that are not part of its licensure or certification. When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL issues a Statement of Findings as required by 55 Pa. Code Chapter 52. The provider is required to respond to the findings with a Corrective Action Plan (CAP) to remediate each finding. If a provider fails to submit a CAP which remediates the lack of licensure or certification requirement, OLTL begins disenrollment proceedings. The provider has the right to appeal.

Subassurance a.i.b- Upon application, OLTL reviews verification submitted by providers who are not required to receive a license or certification in order to provide services. OLTL verifies each provider meets the established regulations and criteria to be a qualified waiver provider. If a provider does not meet one or more of the waiver qualifications, OLTL notifies the provider of the unmet qualifications and provide information on available resources the provider can access to improve or develop internal systems to meet required provider qualifications. If a provider is unable to meet qualifications, the application to provide waiver services is denied. The provider may reapply with OLTL if verification is obtained.

Within two years of becoming a waiver provider (and every two years thereafter), OLTL conducts a provider monitoring of each waiver provider to ascertain whether they continue to meet the regulatory requirements and provider qualifications, including training, outlined in this waiver. The Quality Management Efficiency Teams (QMETs) are the monitoring agent for OLTL. The QMET monitoring tool and database outlines each qualification a provider must meet. The qualifications are categorized according to provider type. Provider type is defined as the service(s) the provider offers to waiver participants as outlined in the service definition. The QMET monitoring tool and database collects the information discovered by the QMETs during reviews for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider develops a Corrective Action Plan (CAP). The provider needs to demonstrate through the CAP that it can meet the regulations and waiver provider qualifications and develop a process on how to continue compliance in the future. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves (or disapproves) the CAP within 30 business days of submission.

The QMET verifies the approved CAP action steps are in place according to the timeframe as written in the CAP. If the CAP is

insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.

Subassurance a.i.c- The QMET monitoring tool ascertains if the provider has completed training in accordance with regulations and waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that providers fulfill training requirements in accordance with state and waiver requirements. If a provider has not met training requirements, the provider is required to submit a CAP. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves the CAP within 30 business days of submission. The QMET verifies the CAP action steps are in place according to the timeframe as written the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## 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, HCB 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:**
Untitled

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

Service Coordination agencies may provide the following services under an Organized Health Care Delivery System (OHCDS):
• Home Delivered Meals;
• Community Transition Services;
• Non-Medical Transportation;
• Home Adaptations;
• Assistive Technology; and/or
• Personal Emergency Response System (PERS).

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

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all wiling and qualified providers, and to document receipt of the Service Provider Choice form in the participant's record. Service Coordinators are also responsible for providing participants with a list of all approved qualified providers during the ISP development process. This list is maintained by OLTL in SAMS. In addition, Service Coordinators are responsible for obtaining the participant's signature on the Service Provider Choice form indicating they were fully informed of all available qualified providers and documenting receipt of the Service Provider Choice form in the participant's record. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination Entity. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H.

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

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

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

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

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

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

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

## Appendix D: 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 assessments and other supplemental documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs. All ISPs must be developed in accordance with 55 PA Code, Chapter 52. The Commonwealth also expects that the person-centered ISP must reflect the services that are important for the individual to address and support needs as assessed through a person-centered functional assessment, as well as what is important to the person with regard to preferences for the delivery of such supports. In order to make fully informed decisions, the Service Coordinator provides and reviews with the participant a standard packet of information developed by OLTL in advance of the ISP meeting. The packet contains information on participant rights and responsibilities, participant choice, applying for home and community-based services programs, the role of the service coordinator, participant complaints, appeals and fair hearings, how to connect to other community resources, participant direction, abuse, neglect and exploitation, and fraud and abuse.

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

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

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

OLTL is responsible for the review and approval of ISP changes. OLTL staff receives all ISP review alerts in SAMS. OLTL staff reviewing these alerts each work day may request additional details or ask for clarification regarding the information that the Service Coordinator has included in the SAMS ISP and comments. Once the ISP is authorized by OLTL, the Service Coordinator ensures that the ISP change or changes are communicated to the participant and shared with the participant's appropriate service provider or providers to ensure that service delivery matches the approved ISP. Changes to the ISP must be approved by OLTL prior to initiating changes in the service plan.

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

At the time of enrollment, the AAA pre-populates the CMI, OLTL's standardized needs assessment tool with the information collected on the LOCA. The prepopulated CMI is then forwarded to the selected Service Coordinator for completion with the participant. The CMI secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator uses the information gathered from the level of care assessment and the CMI to develop the participant's ISP.

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

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

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

The Service Coordinator utilizes the assessments and discussions with the participant to secure information about the participant's needs, including health care needs, preferences, goals, and health status to develop the ISP. This information is captured by the Service Coordinator onto a standard service plan form and then documented in the SAMS. OLTL reviews the participant's record in SAMS against the requirements. The QMET review a sample of claims to ensure they meet the type, scope, amount, duration and frequency of services listed in the ISP. Furthermore, QMET reviews to ensure services are delivered in the type, scope, amount, duration and frequency as indicated in the approved ISP.

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

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

by OLTL, the updated service information is shared with the participant and service providers.

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

How responsibilities are assigned for implementing the plan:
Service Coordinators are responsible for documenting/addressing the following information in the ISP to meet the requirements of OLTL for approval and implementation:
• OLTL services reflect identified unmet needs
• Participant's goals, strengths, and capabilities
• Coordination of waiver/program and non-waiver/program services
• Justification of services
• Preferences addressed
• Third Party Liability
• Informal Supports
• Community resources
• Any risks
• Assignment of responsibilities to implement and monitor the plan
• Individual back-up plan
• Emergency back-up plan
• Freedom of choice of service alternatives
• Choice of providers is offered
• Chosen service model
• Chosen providers
• Review of rights and responsibilities
• Contact with the participant, families and providers in service/journal notes
• Individuals who participated in the development of the ISP
The frequency and duration of all services

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

The Service Coordinator, in conjunction with the participant, is responsible for developing ISPs and updating them annually by performing the following roles in accordance with specific requirements and timeframes, as established by OLTL:
• Developing the initial ISP and subsequent revisions as required;
• Entering ISP's into SAMS;
• Conducting the annual reevaluation at least once every 365 days and whenever needs change;
• Documenting contacts with individuals, families and providers;
• Recordkeeping;
• Locating services;
• Coordinating service coverage through internal or external sources;
• Monitoring services, including the participant's individual back-up plan;
• Ensuring health and welfare of waiver participants;
• Follow-up and tracking of remediation activities;
• Sharing information;
• Assuring information is in completed ISP;
• Participating in ISP reviews;
• Coordinating recommended services;
• Assuring participants are given choice of providers at least annually at the reassessment visit;
• Implementing the participant's individual service plan; and
• Reviewing plan implementation.

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

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

How waiver and other services are coordinated:
A team consisting of the participant, Service Coordinator, and others of the participant's choosing consider all other potential sources of coverage as part of the service plan development process. The team reviews for any service coverage that may be available under the State Plan or other possible Federal programs or non-governmental programs before utilizing waiver services. The team also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the person's health, safety and welfare in the most cost effective manner. All identified services are outlined in the

participant's ISP, which is distributed by the Service Coordinator to the participant and providers of service. The Service Coordinator is responsible for ensuring that there is coordination between services in the ISP, including facilitating access to needed State Plan benefits, maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers. Justification for limitations and/or not utilizing non-waiver services must be documented in service notes. OLTL reviews service plans to ensure that non-waiver resources, including State Plan covered services, are documented on the participant's ISP.

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

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

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

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

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

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

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

The Service Coordinator will also describe any unique circumstances on the ISP. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant when identifying any risks or possible services that would assist the participant

with addressing these risks. A specific service or combination of services may benefit the participant in these types of circumstances.

Emergency back up plans and priority arrangements to ensure the health, safety and welfare of the participant are developed and documented during the ISP development process. Emergency back up plans are also part of the ongoing service plan monitoring process at the Service Coordinator level. All participants are required to have individualized backup plans and arrangements to cover services they need when the regularly scheduled service worker is not available. Strategies for back up plans may include the use of family and friends of the participants' choice and/or agency staff, based on the needs and preferences of the participant. If the backup plan fails, participants may utilize the agency model to provide emergency backup coverage to meet their immediate needs. The Service Coordinator may reach out to and utilize home health or home care agencies for backup if necessary and document the details in the ISP. The Service Coordinator is responsible during regular monitoring to validate that the strategies and backup plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Service Coordinators to report disruptions of backup plans and strategies.

## 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 AAA (or IEB where applicable), educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination Entities, and their right to choose a different provider for different services. Participants are free to change providers at any time by informing their Service Coordinator of the desire to make a change.

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

• A current listing of enrolled providers is maintained by OLTL in SAMS and is automatically updated as new providers are enrolled. The current list is shared with participants by both the enrollment agency as well as service coordination providers.

• Participants are also given the toll free number of the Office of Long-Term Living (OLTL) so they may contact OLTL should they have concerns about their providers or questions regarding their ability to choose providers (including Service Coordination agencies) that provide the services in their service plan. The toll-free HelpLine information is provided to participants at time of enrollment, at annual reevaluations, and during the Service Coordinator's participant service monitoring visits.

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

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

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

OLTL staff reviews ISP information in SAMS. Service Coordinators are required to confirm in SAMS that the standard OLTL Service Provider Form has been completed whenever the Service Coordination provider submits a plan creation or plan revision to OLTL.

## 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 initial ISPs. The Service Coordinator, in conjunction with the participant, is responsible to modify the ISP if the participant's needs change.

When there is a change in the ISP, the Service Coordinator submits that potential change to OLTL through SAMS. OLTL is responsible for the review and approval of ISP changes in SAMS. OLTL reviews a representative sample of ISPs as described in the Quality Improvement section of this Appendix. In addition, OLTL ensures that participant's ISPs are developed according to OLTL requirements and in a fashion that supports individual's health and welfare through the Service Coordination oversight process.

Service Coordinators are required to review and update the participant's ISP at least once every 365 days and submits the annual review

in SAMS. OLTL reviews a representative sample of ISPs as described in the Quality Improvement section of this Appendix. As stated above, OLTL ensures that participant's service plans are updated according to OLTL requirements and in a fashion that supports participant's health and welfare through the Service Coordination oversight process.

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

## 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:

• Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. During monitoring contacts the SC is responsible for discussing the following information with the participant and documenting the information in SAMS service notes for review by OLTL:

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

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

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

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

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

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

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

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

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

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

**b. Monitoring Safeguards.** *Select one:*

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

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

Service Coordination entities may provide the following services under an Organized Health Care Delivery System (OHCDS):

- Home Delivered Meals;
- Community Transition Services;
- Non-Medical Transportation;
- Home Adaptations;
- Assistive Technology; and
- Personal Emergency Response System (PERS).

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

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all wiling and qualified providers. Service Coordinators are responsible for providing participants with a list of all approved qualified providers to the participant during the ISP development process. This list is maintained by OLTL in SAMS. In addition, Service Coordinators are responsible for obtaining the participant's signature on the Service Provider Choice form indicating they were fully informed of all available qualified providers and documenting receipt of the Service Provider Choice form in the participant's record. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement Strategy description in Appendix H

Participants are given the toll free number of the Office of Long-Term Living (OLTL) so they may contact OLTL should they have

concerns about their providers or questions regarding their ability to choose providers (including Service Coordination agencies) that provide the services in their service plan. The toll-free HelpLine information is provided to participants at time of enrollment, at annual reevaluations, and during Service Coordinator's participant service monitoring visits. Additionally, OLTL developed a participant review tool that allows service coordinators to collect information from participants regarding the level of satisfaction with their services. Lastly, the Bureau of Quality and Provider Management distributes a participant satisfaction survey to participants and this provides additional opportunities for participants to report concerns/complaints about their providers.

## 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 Plans (ISPs) adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment Numerator: Total number of waiver participants with adequate and appropriate Individual Service Plans (ISPs) 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 95% +/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**SP-2: Number and percent of waiver participant satisfaction survey respondents who reported unmet needs Numerator: Number of 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |

☑ **Other**
Specify:
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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Two times per 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 participants with Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date Numerator: Total number of service plans reviewed and revised before the waiver participants annual review date Denominator: Total number of waiver participants reviewed**

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check* | **Frequency of data collection/generation***(check* | **Sampling Approach***(check each that applies):* |
|---|---|---|

| *each that applies):* | *each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/-5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**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 participants who are receiving services in the type, scope, amount, frequency, and duration specified in the individual service plan (ISP) Numerator: Numberof waiver participants who are receiving services specified in the ISP 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**SP-5: Number and percent of waiver providers who delivered services in the type, amount, and frequency specified in the Individual Service Plan (ISP) Numerator: Number of waiver providers who delivered services in the type, amount and frequency specified in the ISP 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/- 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Bi-annual QMET monitoring review |

**Performance Measure:**
**SP-6: Number and percent of 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** | **Frequency of data** | **Sampling Approach***(check* |
|---|---|---|

| **collection/generation***(check each that applies):* | **collection/generation***(check each that applies):* | *each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/-5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Two times per year |

**Performance Measure:**
**SP-7: Number and percent of complaints received regarding non-receipt of services Numerator: Total number of complaints regarding non-receipt of services Denominator: Total number of complaints**

**Data Source** (Select one):
**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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative** |

| | | |
|---|---|---|
| | | **Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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: Total number of waiver participants with ISPs that documented an opportunity for choice 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
At the Service Coordination Agency, the SC supervisor reviews the ISP for completeness and appropriateness prior to submitting the ISP to OLTL's Bureau of Participant Operations (BPO) for approval. The supervisor is the first step in the monitoring process.

Staff from the Bureau of Participant Operations (BPO) reviews 100% of new ISPs and 100% of ISPs that have a 10% change in

services using the guidelines specified in the OLTL Service Plan Review Protocol (prospective review).

A representative sample of ISPs is retrospectively reviewed by the Bureau of Quality and Provider Management (BQPM). These reviews are collected in the Retrospective Service Plan Review Database and the data is aggregated monthly, quarterly and yearly for tracking and trending by the Service Plan Assurance Liaison in BQPM. Compliance for twenty nine different SP factors are reviewed and documented in the SP Retrospective Review database. Some Performance Measures (PMs) use multiple factors to determine overall compliance for the PM. Using CMS sampling parameters, the SP Assurance Liaison tracks the sample size to ensure a statistically valid sample has been reviewed.
Data is pulled from the OLTL's Enterprise Incident Management (EIM) database regarding complaints received about service plans. The SP Assurance Liaison reviews a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement.

The SP Assurance Liaison reviews data from the OLTL participant satisfaction surveys for question # 12, pertaining to participant receipt of services in their ISP, and question # 13 pertaining to unmet needs. One hundred percent of returned surveys responses are monitored and aggregated three times a year.

**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, the SP Assurance Liaison, from OLTL's BQPM, issues a Quality Improvement Plan (QIP) to the BPO to address the non-compliance. The BPO submits a plan to correct the non-compliance to BQPM within the prescribed timeframes. As part of the QIP, BPO may contact the SC agency to remediate and follow-up on the issue. The BPO may also provide technical assistance to aid in that remediation.

Complaints regarding non-receipt of service are addressed in EIM processing, and if classified as Urgent , have a timeframe of one day for investigation initiation. See Appendix F for more information on complaint processing.

If BPO, in their prospective review of the plan becomes aware of the need for immediate intervention, contact is made with the SC Agency for intervention. BPO is responsible to follow up to insure the health and welfare of the participant.

If BQPM becomes aware of the need for immediate intervention while conducting a retrospective review of a service plan, notification is made to BPO for follow-up.
Please see Appendix H for more information on Assurance Liaisons and QIPs.

If, through tracking and trending it is discovered that a specific provider has multiple deficiencies, the Quality Management Efficiency Team (QMET) is alerted. The QMET pulls a random sample of the provider's records and reviews the ISPs to verify they meet participant needs adequately and appropriately. If the sample reveals a provider wide deficiency in developing an ISP which meets the subassurances, the provider must complete a Corrective Action Plan (CAP) within 15 business days. OLTL reviews and approves the CAP within 30 business days of submission. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP.

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

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix 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 with the Aging Waiver:
All participants have the right to make decisions about and self-direct their own waiver services. Participants in the Aging Waiver may choose to hire and manage staff using Employer Authority or manage an individual budget using Budget Authority. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

Under Employer Authority, the participant serves as the common-law employer and is responsible for hiring, firing, training, supervising, and scheduling their support worker. Budget Authority, known in Pennsylvania as Services My Way, provides participants with a broader range of opportunities for participant-direction. Services My Way provides participants with greater flexibility, choice and control over their services, by giving participants the opportunity to: 1) select and manage staff that performs personal assistance type services under the Participant- Directed Community Supports service definition; 2) manage a flexible Spending plan; and 3) purchase allowable goods and services through their Spending plan.

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

As stated previously, the participant may utilize a combination of any model(s) to personalize their ISP. The ISP is developed in conjunction with the Service Coordinator and the waiver participant, as described in Appendix D, to ensure that the participant's service

needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer all participants who have chosen to self-direct their services provider-managed services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their Service Coordinator. Service Coordinators must work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

Entities That Support Individuals:
Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing Employer or Budget Authority will receive support from certified Vendor Fiscal/Employer Agents (F/EA) and Service Coordinators to assist them in their role as the common-law employer of their workers. The F/EA will:
• Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants or their representative on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establish work schedules; develop job descriptions; train and supervision of workers; effective management of workplace injuries; and workers compensation;
• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
• Establish and maintain a separate bank account for the purposes of managing participant directed funds and provide a full accounting of the use of these funds;
• Conduct criminal background checks and when applicable, child abuse clearances, on potential employees;
• Assist participants in verifying support workers citizenship or alien status;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's ISP;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through an appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;

• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
• Assist in implementing the state's quality management strategy related to FMS;
• Establish an accessible customer service system for the participant and the Service Coordinator;
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL (Budget Authority only).

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

Participants who choose to manage an individual budget will receive assistance from Service Coordinators to develop the Spending Plan. The Service Coordinator will review and approve the participant's Spending Plan, and enter the plan in to SAMS for OLTL approval. Once the Spending Plan is developed, approved and authorized, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the Spending Plan, the Service Coordinator will assist the participant with the execution and development of the Spending Plan and monitor spending of the Spending Plan.

## 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*:

- [x] **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 documents the participant's choice of service delivery model(s) on the ISP. Participants are also advised that they have the opportunity to change their model of service at any time throughout the year. Participants receive information about participant-direction at time of enrollment, on an annual basis and upon request.

The Office of Long-Term Living has developed consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials include a comprehensive participant reference manual which contains details about participant-direction roles, responsibilities, and informed decision-making. These materials have been distributed to the Independent Enrollment Broker as well as all Service Coordination agencies, and are available on the OLTL website. This information is widely available and shared with individuals upon entering service, at monitoring contacts and during annual ISP updates each year thereafter. This information is written at a level that is easily understood using everyday common language to ensure accessibility, and is provided in advance of the ISP meeting to ensure that individuals have sufficient time to consider their options and the responsibilities.

The F/EA is responsible for providing orientation and training to the participant prior to employing their support worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:
• Review of the information and forms contained in both the Employer and Support Worker enrollment packets and how they should be

completed;
• The role and responsibilities of the common law employer;
• The role and responsibilities of the F/EA;
• The process for receipt and processing timesheets and employee payroll checks;
• The process for purchasing approved goods and services from vendors, including submitting invoices for payment;
• Effective practices for recruiting potential employees, hiring employees, training employees, supervising and managing employees and firing employees;
• The process for resolving issues and complaints; and
• Workers Compensation and the process for reviewing workplace safety issues.

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

## 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:

A personal representative will be required for any individual who is unable to:
• Understand his/her own personal care needs;
• Make decisions about his/her own care;
• Manage his/her lifestyle and environment by making these choices;
• Understand or have the ability to learn how to recruit, hire, train, and supervise providers of care; or
• Understand the impact of his/her decisions and assume responsibility for the results.

The individual, a Service Coordinator, the OLTL, or the F/EA may request a personal representative be appointed, if indicated. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:
• A strong personal commitment to the participant;
• Assist the participant in identifying/ obtaining back up services when a support worker does not show;
• Demonstrate knowledge of the participant's preferences;
• Agree to predetermined frequency of contact with the participant as mutually determined by the participant, the personal representative and the Service Coordinator; and
• Be at least 18 years of age.

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

A representative may not be a paid support worker for the participant.

The F/EA must recognize the participant's personal representative as a decision-maker, and provide the personal representative with all of the information, training, and support it would typically provide to a participant who is self-directing. The F/EA must fully inform the personal representative of the rights and responsibilities of a representative. Once informed, the F/EA must have the representative review and sign the standard OLTL Personal Representative Agreement form, which must be given to the representative and maintained in the participant's file. The agreement lists the roles and responsibilities of the representative; states that the representative accepts the roles and responsibilities of this function; and states that the representative will abide by OLTL policies and procedures.

The Service Coordinator is responsible for ensuring the personal representative functions in the best interest of the participant through, at minimum, quarterly monitoring calls, by monitoring the personal representative's adherence to the Personal Representative Agreement form, and ensuring services are being provided as outlined in the participant's ISP. When it

appears the personal representative is not acting in the best interest of the participant, and there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP, the Service Coordinator must explore other alternatives, such as appointing a new personal representative or transitioning the participant to the provider managed service delivery model as described in Appendix E-1-m below. The Service Coordinator is also required to report any incidents of suspected abuse, neglect and/or exploitation as described in Appendix G.

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

## 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 |
|---|---|---|
| Participant-Directed Community Supports | ☑ | ☑ |
| Participant-Directed Goods and Services | ☑ | ☑ |
| Personal Assistance Services | ☑ | ☐ |
| Respite | ☑ | ☐ |

## 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. The selected vendor must apply the monthly per participant fee consistently with each participant enrolled with the vendor.

•A one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee. The one-time start-up administrative fee is established by DPW.

The one-time per participant start-up fee and the ongoing per member per month administrative fee may not be billed simultaneously. Payment for Financial Managment Services is not based on a percentage of the total dollar volume of transactions that the FMS entity processes. The percentage of FMS costs relative to the participant's service costs are independent of one another, as service costs are based upon the assessed needs of the participant.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

*Specify:*

•• Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants or their representative on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
• Conduct criminal background checks and when applicable, child abuse clearances, on potential employees;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through the an appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
• Assist in implementing the state's quality management strategy related to FMS;
• Establish an accessible customer service system for the participant and the Service Coordinator;
• Assist participants in verifying support workers citizenship or alien status;
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL (Budget Authority only).

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

*Specify:*

The F/EA must provide accurate and timely reports monthly to common law employers, service coordinators, and OLTL. These reports include service utilization, written notification of over and underutilization, and notification of any common law employer who does not submit timesheets for two or more consecutive payroll periods.

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The statewide F/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with the OLTL F/EA contract requirements. The F/EA provides specific employer agent functions that support the participant with the employer-related functions.

The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents.

OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide F/EA will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In accordance with the timelines set forth in Appendix A, if the F/EA is not in compliance with contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, , OLTL will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. Service Coordinators will be required to report any issues with the statewide FMS organization’s performance to OLTL.

Lastly, the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool provided by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department.

Through the established claims oversight process, OLTL will monitors claim submitted by the F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.

## 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 |
|---|---|
| **Therapeutic and Counseling Services** | ☐ |
| **Service Coordination** | ☑ |
| **TeleCare** | ☐ |
| **Participant-Directed Community Supports** | ☐ |
| **Adult Daily Living Services** | ☐ |
| **Participant-Directed Goods and Services** | ☐ |
| **Home Delivered Meals** | ☐ |
| **Personal Assistance Services** | ☐ |
| **Non-Medical Transportation** | ☐ |
| **Specialized Medical Equipment and Supplies** | ☐ |
| **Respite** | ☐ |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies** | ☐ |
| **Assistive Technology** | ☐ |
| **Community Transition Services** | ☐ |
| **Personal Emergency Response Service (PERS)** | ☐ |
| **Home Health Services** | ☐ |
| **Home Adaptations** | ☐ |

☑ **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 that will provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the Aging waiver. One statewide vendor F/EA was selected as a result of the RFA.

The selected F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. In addition, a one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The initial start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee, The monthly administrative fee was established as part of the competitive procurement process; the one-time start-up administrative fee is established by DPW.

Participants will obtain enrollment and informational materials from the selected F/EA organization under contract with OLTL. In addition, the F/EA is responsible for providing orientation and training to the participant prior to employing their support worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:
• Review of the information and forms contained in both the Employer and Support Worker enrollment packets and how they should be completed;
• The role and responsibilities of the common law employer;
• The role and responsibilities of the F/EA;
• The process for receipt and processing timesheets and employee payroll checks;
• The process for purchasing approved goods and services from vendors, including submitting invoices for payment;
• Effective practices for hiring, training, and supervising employees;
• The process for resolving issues and complaints; and
• The process for reviewing workplace safety issues.

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

In addition to the above, the Service Coordinator is also responsible for the following activities when the participant chooses to exercise budget-authority:
• Explain the method for developing the individual budget and share the budget amount with the Participant during the ISP process;
• Assist the participant in developing the individual spending plan if requested to do so;
• Ensure that allowable expenditures for goods and services are made using the participant's individual budget;
• Counsel the participant on the budget and other issues as necessary;
• Assist the participant with service plan modifications within limits of the individual budget; and
• Notify the F/EA regarding changes to the individual budget and spending plan.

The OLTL QMET conducted a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In accordance with the timelines set forth in Appendix A, if the FMS organization is not in compliance with a contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary.

## Appendix 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 participant direction to the provider managed service delivery model at any time by contacting their Service Coordinator who will guide them through the process of transition. When a participant voluntarily chooses to terminate participant direction, they will notify their Service Coordinator. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period, and supports are in place.

## 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 provider managed services.

Involuntary Termination from participant direction may also occur after it has been determined that there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP. Involuntary termination would only occur after a thorough review of the participant's health and welfare needs as identified in the ISP. The Service Coordinator must exhaust all available supports, such as appointing a personal representative, before recommending involuntary termination.

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

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

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

## 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**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 9834 |
| **Year 2** | | 9834 |
| **Year 3** | | 7522 |
| **Year 4** | | 8032 |
| **Year 5** | | 8542 |

## 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 an informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services. The FMS agency secures and pays for the criminal background check.

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-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:*

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**

- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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**

**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.

The participant directed budget is developed based on the Individual Service Plan (ISP). The amount of the individual budget is based on the amounts of service that are authorized in the ISP and are reflected in a participant's Spending Plan. The process for ISP development is the same for all participants in the Aging Waiver, regardless of service model. The Service Coordinator reviews the participant's needs with the participant and ensures that the ISP includes sufficient and appropriate services and provides the support that an individual needs or is likely to need in the home and community and to avoid institutionalization. Once the participant determines that they wish to self-direct, the number of units of Personal Assistance and Respite Services are multiplied by the average regional agency rate for Personal Assistance Services (Procedure Code W1793). This monetized amount represents the participant's individual budget amount and represents the amount that would have been paid on the participant's behalf if they used provider-managed services. Service Coordination and the monthly F/EA service fee are not included in the participant's individual budget amount and is not reflected in the participant's Spending Plan.

The Service Coordinator is responsible for explaining the method for developing the individual budget and sharing the budget amount with the participant during the ISP process. The participant works with the Service Coordinator to determine how the budget can be utilized to best serve their needs while maintaining their health and welfare.

A Spending Plan is developed that uses the available monies to purchase goods and services in a manner that allows the participant increased control and flexibility in the way their services are delivered. The Spending Plan is a detailed plan that describes what, how much and from whom the participant will obtain goods and services that meet his/her needs as identified in the ISP. The Spending Plan also identifies the timing for spending throughout the timeframe of the participant's plan. The F/EA must pay the invoices in accordance with the Spending Plan as authorized by the participant.

Information about participant-directed services, including the method for determining the individual budget, is made available through the SMW training manual, online and the standard participant information materials developed by OLTL.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

**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.

During the ISP process, the Service Coordinator notifies the participant of the individual budget amount following the approval of the ISP by the OLTL, and assists the participant in developing the individual spending plan if requested to do so. In the event that participant needs change, the participant may request an adjustment to their individual budget by contacting their Service Coordinator. As described in Appendix D, the Service Coordinator will reassess the participant's needs and request approval of the revision from OLTL as appropriate. The participant will be notified of the approval or denial of the request. The participant has the right to the fair hearing and appeals process as outlined in Appendix F.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

**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:

Participants have flexibility to manage their services and modify their Spending Plan without requiring the prior preparation of a revised ISP. Funds in the participant's Spending Plan may be reallocated without modifying the ISP when:
1. The participant wants to change an employee's start time.
2. The participant wants to distribute work hours more evenly by assigning more hours to one employee, and this change will not exceed the budget limit.
3. The participant wants to change how an employee will do assigned tasks.
4. The participant wants to reschedule an employee from one day to the next.
5. The participant needs to use the back-up plan.

Participants must notify the F/EA when they plan to exercise their authority to reallocate funds prior to implementing the changes. Upon making the change the participant must meet with the Service Coordinator to document the changes in the Spending Plan.

Any changes that do not meet the criteria above require a change to the ISP and the Service Coordinator's submission to OLTL for approval prior to implementation. To initiate a change of this scope, the participant must meet with his/her Service Coordinator to amend their ISP and Spending Plan. The Service Coordinator will review and approve the amendment. Once the approval is granted the participant will submit an amended plan to the F/EA.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

**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:

Monitoring oversight of the Spending Plan is the dual responsibility of the Service Coordinator and the F/EA. The F/EA will provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL. The participant, Service Coordinator and OLTL will receive written notification from the F/EA when utilization exceeds the monthly budget by 10% or more or when utilization is 80% or less.

The participant is responsible for developing a monthly Spending Plan, with assistance as needed, which will be approved and authorized by the Service Coordinator, and will be utilized to track over and under expenditures.

The F/EA will monitor expenditures, flag significant budget variances, and ensure that the purchase of goods and services and submitted timesheets match the participant's Spending Plan. The F/EA will not reimburse services not documented or authorized in the Spending Plan.

The Service Coordinator will track under-utilization and over-utilization and contact the participant and OLTL to resolve potential service delivery problems. The Service Coordinator must monitor the Spending Plan to assure that expenditures remain consistent with the individual budget, and review the monthly financial reports for the following:
• Under Spending – the participant spends less than 80% of what was authorized for the month, unless there was a hospitalization or other reason for low spending;
• Uneven Spending – the participant's employee's hours are disproportionately being used, e.g., the first two weeks at 75% and the last two weeks at 25%;
• Additional Hours – the participant's employees are being paid additional hours;
• Turnover – high turnover of employees. This should be reviewed over a series of months; and
• Excessive use of agency services for gap filling purposes instead of using back-up services.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

1. The participant is not given the choice of home or community-based waiver services as an alternative to the institutional care

2. The individual is denied his or her preference of waiver or nursing facility services.

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

1. The participant is not given the choice of home or community-based waiver services as an alternative to institutional care

2. The individual is denied his or her preference of waiver or nursing facility services.

3. The participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).

4. The participant is denied the choice of willing and qualified Waiver provider(s).

5. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's ISP or when the participant is involuntarily terminated from participant direction.

The Service Coordinator/AAA (or IEB where applicable) are required to make all such notices in writing utilizing OLTL issued documents. Should the participant/applicant choose to file an appeal, they must do so with the agency that made the determination being questioned. Title 55 Pa. Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department." The agency which receives the appeal from the participant will forward it to the Department's Bureau of Hearings and Appeals for action.

It is the responsibility of the Service Coordinator/AAA (or IEB where applicable) to provide any assistance the participant/applicant needs to request a hearing. This may include the following:
• Clearly explaining the basis for questioned decisions or actions.
• Explaining the rights and fair hearing proceedings of the individual or participant.
• Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the forms.
• Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and providing information to assist the applicant or participant to locate legal services available in the county.
Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AAA participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the initial level of care determination and the individual appeals that notice through the CAO.

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

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the Service Coordinator, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4 (a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the Service Coordinator. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant.

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

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## 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 Office of Quality Management, Metrics and Analytics and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services, provider performance, reports of alleged abuse, neglect or exploitation, and the status of waiver eligibility.

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

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

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

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

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office of Long-Term Living has initiated a comprehensive incident reporting and management process. Critical events are referred to as critical incidents and defined as an event that jeopardizes the participant's health and welfare.

Definitions of the types of critical events or incidents that must be reported:
As defined in 55 Pa. Code, Chapter 52, the following are considered critical incidents:
1. Death (other than by natural causes);

2. Serious Injury - that results in emergency room visits, hospitalizations, and death;

3. Hospitalization - except in certain cases, for example hospital stays that were planned in advance*;

4. Provider and staff misconduct – deliberate, willful, unlawful, or dishonest activities;

5. Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse are, but not necessarily limited to:
• Physical abuse – defined as a physical act by an individual that may cause physical injury to a participant;
• Psychological abuse – an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
• Sexual abuse – an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
• Verbal abuse – using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant.

6. Neglect – the failure to provide a participant the reasonable care that he, or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.

7. Exploitation – the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self, or others;

8. Restraint – Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights.

9. Service Interruption – Any event that results in the participant's inability to receive services that places his, or her health, and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization.

10.Medication errors that require medical intervention, for example, hospitalization, or emergency room visits

* Being admitted for a non-routine medical condition that was not scheduled or planned to occur is a critical incident; a routine hospital visit for lab work or routine treatment of illness of a participant is not a critical incident. A death that is suspicious or of unexplained

causes is a critical incident. A death due to natural causes is not a critical incident.

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

In addition to reporting an incident to OLTL, in the event a direct service provider/Service Coordination Entity has reasonable suspicion that a participant over age 60 is the victim of a crime, including abuse, neglect or exploitation, or that death is suspicious, the provider must also report under the Older Adults Protective Services Agency Act (35 P.S. §§ 10225.101 – 10225.5102 and Title 6 Pa. Code, Chapter 15) and to the local OAPSA agency/the Department of Aging. Providers must also inform the participant's Service Coordination Entity within 24 hours of knowledge of the incident. In addition, the direct service provider/Service Coordination Entity must also immediately contact the appropriate law enforcement official to file a report when incidents involve sexual abuse, serious injury, serious bodily injury or suspicious death. These additional reporting requirements do not supplant a provider's reporting responsibilities to OLTL.

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

Critical incident reports are also taken from participants, families or other interested parties through OLTL's toll-free Participant HelpLine. Additional information regarding the HelpLine is contained in Appendix F.

Timeframes within which critical events must be reported and the methods for reporting:
Required reporters must report critical incidents to OLTL, and Service Coordination Entities when applicable, within 48 hours of their occurrence or discovery. OLTL has initiated an electronic reporting system for reporting all critical incidents. The electronic reporting system affords OLTL staff quick access to the critical incident through the web. Service Coordinators are required to submit incidents through the SAMs system; Aging Waiver service providers are required to submit incidents utilizing the OLTL incident reporting form which is submitted to OLTL through an email resource account: RA_Incident@pa.gov.

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

OLTL reviews the critical incidents daily to ensure for the health and welfare of participants, to check for completeness and to ensure that what has been reported is truly a critical incident. Supervisors in BPO refer cases to their staff for follow-up and action as appropriate.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At time of enrollment, the AAA (or IEB as applicable) informs participants, and their families or legal representatives, of the incident management process and the availability of protective services through the local AAA. This information is provided through the participant information materials developed by OLTL. These materials include how to recognize and report abuse, neglect and exploitation, as well as the prohibition on the use of restraints, seclusion and other restrictive interventions. In addition, the information includes both the AAA's and OLTL's toll free numbers and the process for reporting suspected abuse, neglect and exploitation. The Service Coordinator is responsible for reviewing this information at least annually with the participant, and their family or legal representative, at time of reassessment or if there is suspicion of abuse, neglect, exploitation or abandonment.

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

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

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

If the incident meets the standards of 35 P.S. §§ 10225.101 – 10225.5102, and Title 6 Pa. Code, Chapter 15, reporting to the appropriate protective services helpline must be done within required timeframes.

Investigations that are performed by the Service Coordination Entities include:
• Onsite investigation – An onsite in-person visit is conducted for fact finding. The incident facts, sequence of events, interview of witnesses and observation of the participant and/or environment is required.
• Telephone investigation - Review of the Incident Report (IR) revealed facts are missing or additional information is required and can be obtained through conducting a telephone investigation.

No further action is required when the incident report meets all three of the following conditions:
1) The facts and sequences of events is outlined with sufficient detail; and
2) Preventative action through the service plan is implemented and documented; and
3) The participant is not placed at any additional risk.

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

In cases investigated involving protective services, the Service Coordinator works with the protective service worker to ensure the health and welfare of the participant. This may involve revisions to the service plan as necessary, to meet the participants' needs and to mitigate recurrence of the incident.

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

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

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

**********
CMS Questions and OLTL Responses:

3. In section G-1-d, please indicate the process and timelines for investigations findings that are not completed within 30 days in the WMS application tool.

State response to informal question: There are occasions where investigations will not be completed within 30 days. In all cases, OLTL staff located in the Bureau of Participant Operations contacts the Service Coordinator to obtain details about why the investigation is not completed. If necessary, OLTL staff provides technical assistance to resolve the investigation. If these actions are not successful, OLTL staff will take additional steps to contact the Service Coordination Entity Director to ensure resolution.

CMS additional question: Please provide further clarification in the WMS application tool on the minimum intervals of monitoring that the state will complete when following up on investigation findings that are not completed within 30 days.

Response: OLTL runs monthly reports to determine what critical incidents remain open. OLTL staff in the Bureau of Participant Operations is responsible to follow up with the SC to determine what action is needed to support the participant or reduce the risk or prevent reoccurrence. These activities continue until the incident is closed.

**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 the Bureaus of Quality & Provider Management (BQPM) and Participant Operations (BPO) work together to address critical incidents. BQPM staff reviews reports generated in EIM to track and trend critical incidents. BPO staff work with Service Coordinators and Direct Service providers to assure that participant health and welfare is protected. Together, these two bureaus discuss trends to identify systemic weaknesses or problems with individual providers.

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

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

Service Coordinators play an instrumental role in oversight as well and are required to make quarterly monitoring contacts, a minimum of which two must be in-person. If an instance of abuse, neglect or exploitation is found, the Service Coordinators will immediately refer the case to the local protective services unit, in addition to filing a critical incident policy according to waiver policy.

The Department of Aging maintains a statewide database on all participants who were referred to the Protective Service Unit for investigation of allegations of abuse, neglect, exploitation and abandonment and oversees the Older Adult Protective Services program. The Department of Aging also conducts systematic monitoring and evaluation of the quality of protective services provided by the AAAs while providing the administrative and clinical technical assistance needed to maintain program and service quality.

## 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 AAA (or IEB as applicable) informs participants, and their families or legal representatives, of the prohibition on the use of restraints, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of restraints with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of restraints.

The Office of Long Term Living is notified about unauthorized use or restraints through the Service Coordination Entities and participants. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the unauthorized use of restraints, OLTL requires all Service Coordination providers to annually provide staff training on detection and prevention of abuse and neglect including the use of restraints. All Service Coordinators are instructed to be vigilant for signs of authorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

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

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

○ **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 AAA (or IEB as applicable) informs participants, and their families or legal representatives, of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information and discussing the prohibition of restraints and restrictive interventions at least annually with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use restrictive interventions.

The Office of Long Term Living is notified about unauthorized use of restrictive interventions through the Service Coordination Entities and participants. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of restrictive interventions, OLTL requires all Service Coordination providers to annually provide staff training on detection and prevention of abuse and neglect including the use of restrictive interventions. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

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

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

**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 AAA 9 or IEB as applicable) informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of seclusion with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of seclusion.

The Office of Long-Term Living is notified about unauthorized use of seclusion through the Service Coordination Entities and participants. Once a complaint has been filed, it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of seclusion, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of seclusion. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other

restrictive interventions through their routine monitoring and engagement with individuals.

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

○ **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.

Only participants who require respite services with a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH). Bureau of Facility Licensure and Certification and are subject to the Nursing Home Regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1-483.75.

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.

Nursing Facilities are licensed and inspected by the PA DOH Health, Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75. DOH performs yearly surveys and medication management is part of the survey. Nursing facilities pharmacy management is governed under the following authority 28 pa code § 211.9 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

## 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).

Only participants who require respite services within a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH), Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75.

Department of Health Regulations for Nursing Facilities can be located at the DOH web site at http://www.dsf.health.state.pa.us/health/site/default.asp: scroll down page and click on Nursing facilities, then click Long term care licensure regulation.

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:

PA Department of Health
Department of Public Welfare

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

All identified medication errors are required to be recorded.

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

The Aging Waiver provides services to participants in their own personal residences or in the home of a family member. In the event that a participant requires respite services in a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health, Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75.

( ) **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.

Only participants who require respite services within a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH), Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75.

Department of Health Regulations for Nursing Facilities can be located at the DOH web site at http://www.dsf.health.state.pa.us/health/site/default.asp: scroll down page and click on Nursing facilities, then click Long term care licensure regulation.

## 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 instancesof 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 steps were taken Numerator: Number of unexplained or suspicious deaths for which review/investigation resulted in findings where appropriate follow up steps were taken Denominator: Total number of unexplained or suspicious deaths**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**critical indidents and reports, SAMS**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |

| | |
|---|---|
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-2: Number and percent of substantiated cases of abuse, neglect, or exploitation (ANE) where recommended actions to protect health and welfare were implimented Numerator: Number of substantiated cases of abuse, neglect, or exploitation where recommended actions to protect health and welfare were implimented Denominator: Total number of substantiated cases of abuse, neglect, or exploitation**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |

| | |
|---|---|
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

b. ***Sub-assurance: The state 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 of Urgent complaints with investigation initiated within the required timeframe Denominator: Total number of Urgent complaints**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Critical Incidents and Reports, SAMS**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-4: Number and percent of Non-urgent complaints with investigation within the requited time frame Numerator: Number of Non-urgent complaints investigated within the required time frame Denominator: Total number of Non-urgent complaints**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-5: Number and percent of complaints investigated/closed within the required timeframe**
**Numerator: Number of complaints investigated/closed within the 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***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-6: Number and percent of waiver participants responding to the Satisfaction Survey who indicate knowledge of how to report abues, neglect, or exploitation (ANE) Numerator: Number of participants who indicate knowledge of how to report 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% + - 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Twice 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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Twice 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):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95 +-5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-8: Number and percent of waiver participants with more than three reported incidents within the last 365 calendar days Numerator: Number and percent of waiver participants with more than three reported incidents within the last 365 calendar days Denominator: Number of waiver participants with reported critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**critical incidents reports, SAMS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**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):
**Other**
If 'Other' is selected, specify:
**critical incident reports, SAMS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW-10: Number and percent of reportable incidents investigated within required timeframe**
**Numerator: Number of reportable incidetns investigated within required timeframe**
**Denominator: Total number of reportable critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**critical incident reports, SAMS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

| | |
|---|---|
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**HW-11: Number and percent of critical incidents requiring investigation where the State adhered to follow up methods as specified in the approved waiver Numerator: Number of critical incidents requiring investigation where the State adhered to follow up methods as specified in the approved waiver Denominator: Total number of critical incidents requiring investigation**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**critical incident reports, SAMS**

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** |

| | |
|---|---|
| | Specify: |

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 unauthorized uses of restrictive interventions that were appropriately reported Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported Denominator: Total number of unauthorized uses of restrictive interventions**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Incident management system, SAMS**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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: Number of participants reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**PROMISe claims system, SAMS**

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

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.
Statistical reports on 100% of reported critical incidents and complaints are reviewed monthly by the Bureau of Quality & Provider Management (BQPM) HW Assurance Liaison for patterns in the types of incidents and complaints received, The Liaison is also looking for patterns and issues regarding how the incidents and complaints are processed, i.e. was the reporting timeframe met, etc., according to the elements of the performance measures.

The HW Assurance Liaison reviews data from the OLTL participant satisfaction surveys for question # 16 pertaining to participants who indicate knowledge of how to report abuse, neglect and exploitation. One hundred percent of returned surveys responses are monitored and aggregated three times a year.

Data regarding Services My Way (SMW) participants is stratified from the data for the total waiver population. The data is used for tracking and trending of Health & Welfare issues for SMW participants from the incident, complaint and survey data.

Please see Appendix H for more information regarding the Assurance Liasons role in the Quality Improvement Strategy.

**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 to report the incident utilizing OTLT Incident reporting protocols, investigate, make corrections and/or otherwise meet OLTL incident standards. If immediate action is required to protect the Health and Welfare of the individual the provider is instructed to take such action, When a pattern of not reporting is determined a referral is made to the Quality Management Efficiency Unit (QMEU) for review of the providers' incident protocols and implementation. As issues are discovered, Corrective Action Plans (CAPs) are required of the providers. See the Quality Section of Appendix C for more information on CAPs.

When it is discovered that a participant has more than three reportable incidents within the past 365 days, the Health & Welfare (HW) Liaison reviews and analyzes the incidents to determine the effect on the participant. If the pattern of incidents has an effect on the health and welfare of the participant, the HW Liaison issues a QIP (see Appendix H) for immediate intervention. The QIP, with the Bureau of Participant Operations (BPO) recommendations or action plan, is returned to the BQPM within 15 business days. The BQPM reviews and approves the QIP, notifying BPO of approval and initiating the follow-up process (QIP Protocol).

The BQPM reviews for patterns involving providers, geographic areas, etc. If specific provider(s) are involved in a pattern of

frequent incidents, a referral is made to the Quality Management Efficiency Unit for a targeted review and possible Corrective Action Plan (CAP). The BQPM also refers these participants to BPO through the Quality Improvement Plan process (QIP) under the standard of ensuring health and welfare. Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G.

If the BQPM discovers that a complaint was not acted upon in accordance with waiver standards, the BQPM issues a Statement of Finding and requests a QIP from the BPO.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

OLTL is unable to collect data for two of the incident performance measures regarding time frames since incidents are not yet collected in EIM for the Aging Waiver. Moving the Aging Waiver into EIM is part of the global OLTL work plan; a tentative timeline for completion at this time is November 2013. In addition, OLTL will consider additional performance measures once this data is electronically available.

## 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).
The OLTL developed a QIS for Home and Community Based Services (HCBS) Waivers to measure performance regarding service provision and to ensure the health and safety of participants. The QIS uses the quality management functions of discovery; remediation and improvement to identify and recommend systems improvements.
The Division of Quality Assurance in BQPM is responsible for collecting discovery and remediation information, analyzing that information, recommending system improvements and analyzing the effectiveness of the improvement initiatives. This Division is comprised of the Quality Management Unit (QMU) and the Quality Management and Efficiency Teams (QMET).
The functions of the Division of Quality Assurance are:
• To conduct quality monitoring of long term living programs and services to ensure compliance with federal and state regulations and the 6 waiver assurances
• To conduct provider monitoring to align with the 6 assurances to gather accurate data to determine compliance
• To compile reports for on data for the 6 assurances to measure the effectives of program design and suggest improvement initiatives
• To use data to support the development and implementation of policies and protocols to insure quality program outcomes
• To develop and implement training and technical assistance for staff, providers and participants to insure quality service delivery
• To convene a Technical Assistance Workgroup comprised of OLTL staff to insure consistent policy communication to providers and staff
• To collaborate with other bureaus in the OLTL, external stakeholders, other state agencies and the Quality Council to effectively implement this QIS
• To recommend strategies for continuous quality improvement
• To maximize the quality of life, functional independence, health and welfare and satisfaction of participants in OLTL waivers
The following reports are used to collect data which is then analyzed by the QMU to implement the QIS. The frequency of data compilation is indicated after each report. Each of the reports listed below was specifically designed to collect the data needed to assure compliance. The QMU works with various other bureaus and divisions in the OLTL to ensure the reports and data collected are valid and being set up and compiled correctly. The reports are monitored to determine possible causes of aberrant data and compliance issues.
Administrative Authority Assurance:
• Level of Care Determination Report - Quarterly

• Independent Enrollment Broker Contractual Obligation Report for Area Agencies on Aging - Quarterly
• Initial and Annual Level of Care Report - Quarterly
Qualified Provider Assurance:
• Qualified Provider Report - Quarterly
• Initial Provider Enrollment Report - Quarterly
Service Plan Assurance:
• Service Plan Assurance Data Report - Monthly
• Participant Satisfaction Survey Results – 3 times per year
• QMET Report on Service Delivery - Quarterly
• Enterprise Incident Management (EIM) Report on Complaints - Monthly/On Demand
Health and Welfare Assurance:
• Three EIM Reports on Complaints and Incidents – Monthly/On Demand
• Participant Satisfaction Survey Reports – 3 times per year
Financial Accountability Assurance
• Onsite Paid Claims Report - Quarterly
• PROMISe Paid Claims Report - Monthly
• FEA Deliverable Report - Monthly
The reports obtained are reviewed by Quality Management Liaisons (QML) in the QMU. Data is analyzed and reviewed for each assurance. When areas of low compliance are identified, strategies to mitigate the non-compliance are discussed first with the Unit Supervisor, then Division Director and subsequently at the Quality Management Meeting with representatives from each bureau in OLTL in attendance. At that meeting, each member of the group suggests and discusses ideas to increase compliance with the particular assurance previously identified as problematic. An agreement is reached on a plan to roll out to involved entities, such as providers or contracted entities. The bureau responsible for the entity is directed to implement the plan and follow up for technical assistance. Compliance with the assurance is then monitored closely to insure the compliance rate increases. If this is not the case, the process begins again until the compliance rate increases to the acceptable level.
Also part of the QIS is the Quality Council. The Quality Council meets quarterly is comprised of internal and external stakeholders who are presented with issues regarding non-compliance and make recommendations for change.
Quality information is reported to agencies, waiver providers, participants, families and other interested parties in several ways. The OLTL distributes information 4 times per year at the Quality Management Meeting. After discussion, at the Quality Management Meeting, the data is presented at the Quality Council Meeting quarterly. Quality information is also presented at the Department of Human Services (DHS) Medical Assistance Advisory Committee Meetings as requested. These meetings involve DHS and stakeholders. The OLTL also provides data as requested to providers, participants and other parties. Results from the Participant Satisfaction Survey are posted on the DHS website 3 times per year. Results from provider monitoring are communicated to providers as soon as possible after the monitoring takes place.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☐ **Annually** |
| ☐ **Other**<br>Specify: | ☐ **Other**<br>Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Summarized below are the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each assurance.
1. The QML for each of the assurances reviews the data collected to determine compliance issues.
2. The data collected is aggregated for tracking and trending.
3. The QML makes initial recommendations and prioritizes issues for problem solving and corrective measures to the Unit Supervisor.
4. The Unit Supervisor reviews the recommendations and presents the issue to the Division Director.
5. Issues are then placed on the agenda for the Quality Management Meeting and the Quality Council Meeting.
6. At the Quality Management Meeting and the Quality Council Meeting, issues and data are presented to the members.

7. Recommendations are made to remediate the issue.
8. The Director of the BQPM makes the decision on which plan will be used to remediate.
9. The appropriate bureau implements the plan with the responsible entity and provides technical assistance to implement the plan.
10. The QML insures that the plan was successful by reviewing the compliance data following implementation of the plan.
11. The QML reports on the remediation of the issue at Quality Management Meetings.

This process outlines the OLTL QIS. The QIS is reviewed at each Quality Management meeting (quarterly) to insure the QIS is working and on target.

The roles and responsibilities are as follows:

QML
• Identify and collect needed data
• Insure that data from reports is valid and accurate captures compliance with the 6 assurances
• Aggregate, review and analyze data to identify issues and trends
• Identify compliance issues
• Look for aberrant data and determine causes
• Make initial recommendations for problem solving, corrective measures and system changes
• Follow up on effectiveness of remediation plan and recommend alternatives if plan is not achieving desired result of reducing non-compliance
• Develop mandatory training for Service Coordinators on Assurances

Unit Supervisor and Division Director
• Review QML issues and recommendations for inclusion in Quality Management and Quality Council Meetings
• Maintain an Issues Chart to track progress on remediation and system changes and insure the issue is resolved and non-compliance is reduced
• Hold monthly meetings with other OLTL Directors to discuss trends and plans to correct quality issues.

Representatives from OLTL Bureaus and Quality Council Members:
• Attend meetings
• Make recommendations and suggestions to remediate issues and system changes
• Review recommendations made by QML
• Monitor follow up and results

BQPM Director
• Make final decision on plan to be followed to remediate issues

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

The process to continuously assess the effectiveness of this QIS and revise as necessary is as follows:
• Two years after the waiver renewal date, a Quality Management Meeting will be held with the sole purpose of looking at the QIS and evaluating the effectiveness of the strategy.
• Prior to submission of the Evidentiary Based Review for the waiver renewal, another Quality Management Meeting will be held for the same purpose.
• Independent persons not associated with OLTL will be invited to access the effectiveness of the strategy.
• The Issues Chart will be made available along with a summary of the steps taken to resolve the issues.
• The Independent Reviewer will access and make recommendations for change.
• Annually a Quality Management Meeting will be dedicated for review of the Issues Chart and recommendations for change.

The Quality Improvement System outlined also applies to the Aging (control number 0279), OBRA (control number 0235), Independence (control number 0319), CommCare (control number 0386) and AIDS (control number 0192) Waivers. OLTL has incorporated all of OLTL's 1915 (c) waivers into a global Quality Improvement Strategy. The discovery and remediation data gathered during the implementation of the QIS are waiver specific and stratified. Because the renewals are staggered, the QIS automatically receives a periodic evaluation during the point of the renewal of each waiver.

## 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:

1. Providers shall comply with the Federal audit requirements as specified in Section 74.26 of 45 CFR (relating to non-Federal audits).

2. Providers who meet certain thresholds as specified in OMB Circular A-133, as revised, and the Department of Public Welfare's (DPW) Annual Single Audit Supplemental Publication are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-

502, as amended, and to complete DPW's annual Single Audit Supplement publication.

3. Providers who are not required to comply with the Singe Audit Act of 1984 during any program year shall maintain auditable records in compliance with PA Code §52.43.

4. DPW may request that a provider have the provider's auditor perform an attestation engagement; DPW or DPW's designee may perform an attestation engagement; or DPW may request that the provider's auditor conduct a performance audit in accordance with the following:
a. Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards.
b. Standards issued by the Auditing Standards Board.
c. Standards issued by the American Institute of Certified Public Accountants.
d. Standards issued by the International Auditing and Assurance Standards Board.
e. Standards issued by the Public Company Accounting Oversight Board.
f. Standards of successor organizations to those organizations in paragraphs a. through e. above.

In all cases, providers must retain auditable records for at least 5 years from the provider's fiscal year-end. If the provider has a settlement of claims as a result of litigation, then the provider must retain auditable records 5 years from the end date of the litigation or 5 years from the provider's fiscal year-end, whichever is greater. Additionally, the provider must retain records beyond the 5 year period DPW or another State or Federal agency has unresolved questions regarding costs or activities of the provider.

Payments to providers are also controlled by edits built into the commonwealth's MMIS system known as PROMISe. Claims for services are matched against the eligibility system (CIS) so that payments are not made for recipients that have not been approved for Medicaid and for the waiver. Additionally, the PROMISe system will not pay claims if a participant does not have either the service or the provider included in the approved service plan for the recipient in the HCSIS system.

The Office of Long-Term Living's (OLTL), Quality Management Efficiency Teams (QMET) conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. In order to conduct these post payment reviews, the QMET's review PROMISe claims reports against provider's time sheets, paid invoices and other sources provided to verify accuracy of services rendered.

Depending on the findings of the QMET reviews, remediation may include:
• Suspending claims pending review prior to payment.
• Review of provider's records.
• Review of provider's written billing policies/procedures.
• Sanctions, prohibition or disenrollment from providing services.
• Prohibition from serving new participants.
• Provider refund of inappropriately billed amounts.

Providers may also be selected for a GAGAS performance audit by the DPW Bureau of Financial Operations.

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

QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). The ISPs are developed by service coordination entities along with participant input and based upon an assessment of the participants needs. Monitoring of the financial records provides the opportunity to reevaluate the ISPs by looking at utilization of services to identify trends such as underutilizing services and overutilization.

In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc.

At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.

The sampling methodology is based upon a statistical calculation in which we take each of the items (participants/employees/billed claims) required for review and create a sample based off of a confidence rate of 95% (a 95% certainty) and confidence interval (margin of error) of 10. Additionally, QMET has the option of judgmentally adding to this sample at the professional discretion of the reviewer. In

cases that the random sample has missed items that are may need attention, or if separate items cause issue or suspicion during a review, those items may be added to our sample.

Any review we have on a providers cost accounting systems would be minimal. We gather, from the provider, an independent audit (if completed) and financial documentation such as balance sheets, tax returns and bank statements. We do not perform any formal testing/review of these documents. These documents are viewed onsite by the Financial Representative(s), and if there are any unusual items or obvious cash flow and/or going concern issues, we are to make note. We don't review in detail any internal controls, ledgers, costs, or budgeting documentation at the agencies.

The HCBS Field Operations Manager is responsible to direct five (5) regional teams which monitor and report data on provider compliance. These regional teams are collectively called QMET. The majority of QMET is comprised of contract staff. The regional teams include financial representatives that are responsible in conjunction with other team members to perform monitoring reviews.

Responsibilities of the financial representative include, but not limited to, assessing whether or not the provider entity has maintained sound fiscal practices, billed DHS properly, and used DHS funds in accordance with program guidelines, determine the appropriateness of costs claimed for DHS subsidy, determine whether an entity is managing and utilizing its resources economically and effectively and identify the causes of inefficient or uneconomical practices.

In addition,when overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken by the Division of Provider and Operations Management. Providers will receive a series of letters outlining what steps they must take, within a specified time frame, to correct the overpayment. The first letter outlines the overpayments that have been identified and allows the agency to submit further supporting documentation to validate the payment received. The provider is given a 15 day window to comply with this request. If the provider cannot or does not respond, a second letter outlines that they have an additional 15 days to comply or the Department will begin to recover the identified overpayments through either adjustments to future claim payments or a lump sum payback. If OLTL receives no response or the provider agrees with the overpayment, the Department discusses payment methods with the agency and either allows a one-time payment via check, a monthly payback via check, or reduces future payments to that agency until the full amount of the overpayment is recovered.

All allegations of suspected fraud and financial abuse are directed to the Bureau of Program Integrity (BPI) within the Department of Human Services. Instances are reported by calls, letters and emails from providers, participants, care workers, witnesses etc. In addition to reports that are received directly to BPI, QMET staff may discover potential instances of fraud and abuse during the course of on-site monitoring. Pertinent information is compiled by QMET and forwarded on to BPI for investigation.

Please note, OLTL does not license or prior authorize services.

In order to assure that each claim is processed in accordance with the approved waiver OLTL-specific edits and audits were developed and are maintained for the State's CMS certified Medicaid Management Information System (MMIS). PROMISeTM is the MMIS utilized for claims processing. Claims that are incomplete or contain invalid Information are denied to ensure compliance with what is specified in the approved waiver.

Providers are subject to on-site reviews every two (2) years. As part of the on-site review, a retrospective review of claims is conducted. Based on deficiencies found during the on-site review, a subsequent claim sample may be pulled and reviewed as part of the follow-up. Timeframe for conducting the CAP follow-up is dependent upon the dates for completion identified by the provider. QMET determines the CAP follow-up monitoring schedule and the method (on-site vs in office) based on the action steps that were to be completed. CAPS are to be followed-up on between 30 and 90 days of the last date listed under timeline for completion. Additional time frames for more frequent monitoring and claim sampling are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

A provider which is not required to meet the threshold for an annual audit will maintain auditable records. The provider will maintain books, records and documents that support the type, scope, amount, duration and frequency of service provision.

## 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 in accordance with the approved waiver Numerator: Total number of claims that paid as specified in the waiver Denominator: Total number of paid claims**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**PROMISe paid claims system, SAMS**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**FA-2: Number and percent of providers 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, off-site**
If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| | |
|---|---|
| | |

**b.** ***Sub-assurance: The state 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 of provider payment rates that are consistent with approved rate methodology Denominator: Total number of provider payment rates**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**PROMISe claims data, documentation from State rate setting division**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |

| | |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.
A Paid Claims Report is processed by OLTL Bureau of Quality & Provider Management (BQPM) against all paid waiver claims (100% sample) on a monthly basis, within the PA PROMISe MMIS claims processing system to verify that only valid procedure codes are paid. The Financial Accountability (FA) Assurance Liaison aggregates the reports for longitudinal monitoring.

The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. Using a standard monitoring tool which incorporates the Financial Accountability requirements as listed in the waiver, the QMET verifies each requirement during the review. Random samples of provider employee and consumer financial records are reviewed to ensure compliance with waiver standards.

Services My Way reports are prepared by the OLTL Financial Management Services vendor using a combination of Administrative Data, HCSIS and payroll, in a 100% sample, on a monthly basis. The Financial Accountability (FA) Assurance Liaison analyzes the data to determine performance measure factors.
The report/ review will be 100% of AAAs that have enrollment activity within each quarter. The report will include every AAA, but some of them might not have any enrollment.
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 claims would pay and not be valid, the circumstances of each claim would be investigated (did the codes change, are the codes loaded into PROMISe correctly, etc).
After the end of each calendar quarter, The QMU Liaison runs the reports the following month from the PA EDW (Enterprise Data Warehouse) system as it is updated. The data is reviewed to determine level of compliance. Data is tracked and trended against prior periods. Remediation is taken if needed.
The QMU Liaison reviews the report that has been run. If no claims are listed on the report, all of the paid claims paid using correct procedure codes that are valid under the waiver. Any claims that would be listed on the report would be investigated to determine why they are incorrect.
The QMU Liaison reviews the data that has been reported by the QMET teams. The data is tracked and trended against prior reporting periods to draw conclusions relating to levels of compliance.
The QMU Liaison reviews the report that has been run. Any claims that do not pay at the correct rate will not meet the Assurance. These claims would be reprocessed at the correct rate.
Universe. FA-1: Numerator: Total number of claims that paid using correct procedure codes. SFY 2013-14 – 881,396 claims. Denominator: Total number of paid claims. SFY 2013-14 – 881,396 claims.
766 total providers. Numerator: number of providers reviewed that paid correctly. Denominator: number of providers reviewed during each quarter.
140 payment rates.
Paid Claims Report is analyzed. Based on results, further investigation of the paid claims and processing system may be needed.

Based on the results from QMET on site findings, providers will make necessary changes through the Corrective Action Plan remediation process. OLTL is exploring the option of collection this data systemically instead of onsite reviews.
Rates will not become official without passing the PA review process that they were done using the correct methodology.
If a claim passed all of the edit and audit checks in the PA PROMISe claims processing system, they have been coded and paid for in accordance with the reimbursement methodology.
QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.
Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for

the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc.

At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.
Pennsylvania contracted with a vendor to assist with setting the payment rates. Parameters were agreed upon that would be critical to achieving the rate setting methodology. The rates went through a comment and vetting process. These accepted approved rates are loaded into the PA PROMISe payment processing system that the claims pay against.

The State uses the following website to determine sample sizes: http://www.raosoft.com/samplesize.html

**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/BQPM initiates steps to recoup the overpayment.

Noncompliance discovered during QMET monitoring is remediated through Corrective Action Plans (CAPs), requiring providers to submit their action steps to remedy their non-compliance.

Systemic issues/defects are addressed through the Department's Bureau of Data and Claims Management, the Bureau of Information Systems and the appropriate systems contractors related to the primary claims processing system (PROMISe™) and its interfaces. When systems issues occur, trouble tickets are generated by the Office of Long Term Living (OLTL) and defects are researched, identified, and corrected by the appropriate systems contractor. All claims impacted by the systems issues during processing are identified by the claims contractor and reprocessed after the correction to the system is made. OLTL sends communications to the providers that are affected making them aware of the issue, what is being done to correct it, and the timeline for completing the correction of the system issue.

Accurate and timely claims processing is performed within the MMIS system (PROMISe™). The claims processing capability accommodates, from receipt through adjudication, the unique identification, editing and auditing, pricing, claim resolution, claim adjustment processing, tracking, controlling, and reporting of every claim transaction as it progresses through all facets of claims processing.

The timeframe for conducting the CAP follow-up is dependent upon the dates for completion identified by the provider. QMET determines the CAP follow-up monitoring schedule and the method (on-site vs in office) based on the action steps that were to be completed. CAPS are to be followed-up on between 30 and 90 days of the last date listed under timeline for completion. The provider is notified of the type of follow-up to be performed 10 business days in advance of the follow-up monitoring. Regardless of the manner of follow-up, all documents reviewed should be of sufficient quantity and scope in order to determine if the action steps have been completed accurately, timely, and in accordance with the approved plan. If the follow-up is performed and all the action items are verified as complete the CAP is closed. If some items remain incomplete, QMET will provide technical assistance in order to assist the provider in remediating any outstanding items and work towards closing the CAP. No CAP is closed until all action steps have been completed.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

- (selected) **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 related to the delivery of the service, as defined in Department standards and a review of cost data as supplied from providers. The fee schedule rates represent the maximum rates that DPW will pay for each service. In developing rates for each of the MA fee schedule services, the following occurs:
• OLTL evaluates various independent data sources such as Pennsylvania-specific compensation data supplied by the PA Bureau of Labor Statistics and considers the expected expenses for the delivery of the services under the waivers for the major allowable cost categories listed below:
-Wages for staff
-Employee-related expenses
-Productivity
-Program Indirect expenses
-Administration-related expenses
• OLTL develops geographical fees to reflect consideration for differences in wages observed across the Commonwealth.
• The fee schedule rates are established by the Department to fund the fee schedule services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.
• Rates for the following services are on the waiver fee schedule: personal assistant services, service coordination, home health care services, respite (agency and participant directed) and therapeutic and counseling services.
• Additionally, OLTL reimburses the following services: Accessibility Adaptations, Durable Medical Equipment and Supplies, Non-Medical Transportation, Participant Directed Community Supports, Participant Directs Goods and Services, Personal Emergency Response System, Home Delivered Meals and Telecare Services based on the cost charged to the general public for the good or service.

• Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.
• Once published in the Pennsylvania Bulletin, the rate notice and corresponding rates are available on the OLTL website for participants, providers and the general public's information. In addition, when the participant chooses to self-direct some or all of their services, the F/EA is responsible for informing the participant of the established rate for that service.

OLTL obtained public comment on the rate determination methods in a variety of formats which include, stakeholder workgroup discussions, draft documents distributed for comment, communications and other meetings.

OLTL obtains comments on rates in a variety of ways. Feedback is solicited through various forums, including convening a provider workgroup, conducting on-site provider interviews, issuing an all-provider survey, and providing updates at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC). In addition, once rates are determined, OLTL published a rate notice in the PA Bulletin with a 30-comment period. Comments received are considered in subsequent revisions to the MA Program Fee Schedule.

In OLTL's F/EA participant-directed services model, the Common-Law Employer (CLE) (who may be the waiver participant or his/her representative) chooses an hourly wage per service to pay the Support Service Workers (SSW) who render waiver services to the waiver participant. The unit rate for SSWs is established by OLTL and is published on the rate schedule. The F/EA then submits a claim for the service to the Department in the amount of the negotiated wage plus associated costs for taxes, workers comp and unemployment

insurance. It is the responsibility of the F/EA to inform the CLE and the participant of the maximum amount the SSW can be paid based on the OLTL-established rate minus costs for taxes, workers comp and unemployment insurance. The CLE then determines the wage paid to the participant's SSW. The F/EA reviews and confirms that the wage for the SSW is within the established rate.

As noted above, OLTL establishes the unit rate from which the CLE selects an hourly wage for the SSW. The F/EA SC reviews and confirms the selected wage is within the established rate for the service, which ensures that the integrity of the wage-setting activity.

Please refer to the public notice at http://www.pabulletin.com/secure/data/vol42/42-23/1058.html for a summary of the rate development process.

The link to OLTL's current Rate Schedule is:
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/p_033877.pdf

The link to OLTL rate notices is: http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/providers/index.htm

The fee schedule rates were mainly developed using a market-based approach. This approach uses the most current available market data, as opposed to provider-specific cost data. In the few cases where provider data were available, it was reviewed to help inform the fee development process, but fees were not set solely on reported provider costs.

OLTL does not annually collect formal cost reports from all providers. In some cases, OLTL will query providers about a certain cost component and use the information to help inform the fee development process.

After allowable cost components are identified and market data are reviewed (as described in the response to Q1), the process used to calculate the MA fee schedule rates starts with the assumed direct care worker salary expenses. Consideration for all employee-related expenses and productivity adjustments are loaded on top of the wage to calculate a full hourly cost for the direct care worker. Once this amount is established, other program indirect costs are factored in followed lastly by the loading on of administration expense considerations. The resulting hourly amount is converted to the appropriate unit definition for the given procedure code (e.g., 15 min, day).

Given the nature of HCBS services and flexibility for states to design services specific to the population served, direct comparisons to rates in other programs within a state or comparisons to rates in other state's waiver programs may not be meaningful. OLTL is aware of fee schedule rates utilized for similar services in other MA programs in the Commonwealth and makes an effort to understand reasons for variance, where appropriate.

OLTL fee schedule rates are developed for four distinct geographic regions in order to reflect differences in service delivery costs across regions. Region 1 represents Pittsburgh and surrounding counties, Region 4 represents Philadelphia and surrounding counties, Region 3 represents Harrisburg and surrounding counties and Region 2 represents all other counties. Refer to the regional fees at the following link: http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101249.pdf.

Refer to the following link for a description of the regions and the approach: http://www.pabulletin.com/secure/data/vol42/42-23/1058.html

The fee schedule rates are not adjusted for acuity determination considerations, as differences in acuity are reflected through the use of different staffing ratios or intensity levels for some services. In years when a fee schedule re-base has not been performed, OLTL reviews the fee schedule and applies a cost of living (i.e., inflation factor) adjustment, if needed. No other adjustments were considered to develop the final fee schedule rates.

Although not explicitly stated in Appendix I, the rate development process establishes rates specific to the unit definition for each procedure code (refer to the unit definitions by procedure code in the rate table found at the link below). These unit definitions are consistent with the units of service displayed in Appendix J.

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101249.pdf

Fee schedule services vary depending on the geographic region of the provider as outlined in the region summary found at the link below.
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101252.pdf

Home Adaptations, Assistive Technology, Specialized Medical Equipment and Supplies, Vehicle Modifications, Non-Medical Transportation, Community Transition Services, and Personal Emergency Response Services are all vendor services, which means that the vendor may charge what is "usual and customary" for the general public. OLTL does not determine the provider's Usual Customary Charge (UCC). If OLTL had cause to investigate, OLTL would request the provider's documentation to support their UCC (like their fee schedule), and maybe some other records to show that the provider actually applied that UCC to individuals in the general public.

While monitoring providers on-site, the Quality Management Efficiency Teams request all mileage sheets and/or receipts from buses, taxis or other modes of transportation related to non-medical transportation. The Financial Representative then compares them to the amount billed and paid. Staff then reviews the participant files for the individualized assessment which was performed determining the participants need, and contact notes in HCSIS or SAMS to verify that the service approved was provided.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to

the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Providers are reimbursed retrospectively based on services provided.

Providers must submit claims through PROMISe, DPW's MMIS system. This system is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS).

In order to be paid for submitted claims providers must be enrolled as Medical Assistance providers and entered as such into PROMISe.

PROMISe verifies participant information in the Client Information System (CIS) which contains MA participant's eligibility information, such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates.

Service plan information is managed in the SAMS System. Changes that are made to service plan information in SAMS are transferred to HCSIS (Home and Community Services information System) on a daily basis through a nightly upload.

PROMISe also verifies with HCSIS that the provider(s) and service(s) on the claim are included in the participant's approved waiver service plan.

Service Coordination providers that also serve as Organized Health Care Delivery Systems (OHCDS) providers (further outlined in Appendix I-3, g. ii. below) may serve as the fiscal intermediary for certain specified services. The OHCDS whether subcontracting or directly reimbursing the cost of the service provided by a provider or vender may not bill more than the actual cost of the service. The OHCDS will bill through PROMISe and all of the edits, systems checks, etc. as listed above will pertain.

Billings for recipients that choose to self direct their services are more fully outlined in Appendix E. For Participant- Directed Personal Assistance Services, the F/EA will submit claims to PROMISe on behalf of the waiver participant employer. These claims will be billed through PROMISe, again going through all edit and system checks outlined above. The claims will only be submitted for appropriately approved direct care worker timesheets.

Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS, or select any other enrolled qualified provider. The service would be listed once on the service plan either under the SC acting as the OHCDS or the enrolled qualified provider. Only the enrolled OHCDS or enrolled qualified provider would have the ability to bill for the service through PROMISe™.

OLTL's HCBS waivers do not have cost settlements. This statement means that providers are reimbursed after services have been rendered.

Direct care workers may submit timesheets to the F/EA via facsimile, mail, or web portal for processing. Paper timesheets that are submitted via mail or facsimile must be signed by the participant for verification of services received and issuance of payment. Timesheets submitted via the web portal must be approved by the participant-employer prior to payment. Timesheets are validated against the participant's eligibility and service authorization information imported to the F/EA's web portal. Once validations are processed the F/EA submits claims through PROMISe™ on behalf of the participant employer. The claims process through the same edits and systems checks as other OLTL provider claims.

The State validates this information through the Service Coordination Entities (SCE). SCEs are responsible to monitor the delivery of services and supports. This is done through on-site visits and phone calls and includes verifying that the services reported on timesheets were actually received. In addition, SCEs are responsible to review utilization reports and the service plan with participant to ensure services are being provided in accordance with the service plan. In addition, they are responsible to report any temporary gaps in service.

The Department's F/EA vendor has a contractual relationship with the Commonwealth that was established through a competitive bidding process. All payments to the F/EA, including administrative fees, are specified in the contract. Administrative fees are not included in the participants' service costs.
Administrative fees are paid to the vendor through PROMISe™, the state's MMIS.

All claims editing and auditing (not only the edits/audits in the ClaimCheck application) determines what services and how many of those services on the claim should be paid in accordance with the waiver. Logically, once all payable services, quantity of those services, and fees for those services on a claim are determined and validated through the editing and auditing processes the claim can be priced and sent to financial for final processing.

## 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.

Billing validation is done first through PROMISe. PROMISe verifies participant information in the Client Information System (CIS), such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Aging Waiver.

After validation of the above listed items occurs, the claim information is sent to the Home and Community Services Information System (HCSIS) to be verified against the participant's ISP which is managed in the SAMS System. SAMS data is transferred to HCSIS (Home and Community Services Information System) on a daily basis through a nightly upload. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This fiscal accountability of services rendered provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. Resolutions of denied or suspended claims occur through error code notification.

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for and the cost of services provided under the waiver. OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. OLTL reviews HCSIS reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews. Finally, Service Coordinators are responsible for ensuring the proper information is entered into SAMS correctly so providers can bill timely and accurately. Service Coordinators are responsible for monitoring the participant's ISP to ensure the participant is receiving the services as authorized in the ISP.

As part of the comprehensive on-site monitoring conducted by QMET, participant files and service notes are reviewed to ensure that the services authorized have been received. Claims are reviewed to verify that billing is supported in the correct type, scope, amount,

duration and frequency (TSADF) as written in the individual service plan (ISP).

Claims are retrospectively reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc.

All unsupported overpaid claims identified by the TSADF review is reported to the Division of Provider and Operations Management for recoupment purposes.

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.**
- [x] **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:

Most of the Area Agencies on Aging provide Service Coordination and all provide Community Transition Services.

The rate for Service Coordination is the same for both public and private providers, and is established on the MA fee schedule. OLTL does not reimburse providers based upon costs or conduct cost settlements for its HCBS waiver services.

AAA's may not bill for both Transition Coordination through OLTL's state funded Nursing Home Transition program (NHT) and Transition Service Coordination through the Waiver program in which the individual is enrolled.

Community Transition Services (CTS) available through the waiver programs: If an individual is transitioning from a nursing facility to their home and is approved for a waiver program, the provision of Transition Service Coordination related to coordinating the five specific Community Transition Services as defined within the service definition in Appendix C-3 should be billed separately, using the established billing procedure code of W7337. The Transition Service Coordination services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution. The delivery of payment is contingent upon a transition into an OLTL waiver and is documented on the participant's ISP.

Transition coordination through OLTL's state funded Nursing Home Transition Program (NHT) can be billed from the time an individual agrees to participate in NHT up to and including the day the individual transitions into the community. Payment for transition coordination under the NHT program is not contingent on a transition to the community. NHT payments are made after OLTL staff review quarterly invoices generated from SAMS and authorize reimbursement for activity that has been appropriately

documented.

## 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:*

- (●) **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.
b. Eligible entities may request enrollment. Such requests are reviewed and approved by OLTL prior to any service provided through the OHCDS arrangement.
c. As described in Appendix D, individuals are fully informed of their right to choose from all willing and qualified providers and are not required to utilize the OHCDS arrangement. Providers who do not wish to affiliate with an OHCDS may always directly enroll as a provider with the Department.
d. Through robust provider/SC oversight and monitoring, as well as through information garnered through service plan and claims data, OLTL monitors services provided through OHCDS to ensure that the OHCDS has contracted only with providers meeting established minimum qualifications.
e. Through these oversight mechanisms, OLTL will also ensure that the arrangements meet State and Federal requirements.
f. The full amount of service dollars is passed through for the provision of service.
g. The State assures financial accountability when an OHCDS arrangement is used by monitoring individual service plans and claims paid to the OHCDS entities through the comprehensive provider and SC monitoring processes performed by OLTL. The state ensures that the payment to the OHCDS does not result in excessive payments through the established process of paying only the cost of the service or good provided.

http://www.pacode.com/secure/data/055/chapter52/chap52toc.html

If a service coordination entity is an OHCDS, it may subcontract the services. In its subcontracting activities, the provider must have a written agreement containing the OHCDS and the subcontractor's duties, responsibilities and compensation. If an OHCDS subcontracts with an entity to provide a vendor good or service, the OHCDS shall ensure the entity complies with 55 Pa. Code Chapter 52.51 related to vendor good or service payment. The OHCDS bills the Department for the vendor good or service and then pays the subcontractor. The OHCDS is responsible to ensure that the subcontracting agency is only charging what the good or service costs the general public, and the OHCDS may not charge an administrative fee or any additional costs.

**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:

Services will be provided to eligible waiver participants throughout the Commonwealth. Each individual enrollee receives services in accordance with his/her individualized service plan based upon the assessed needs. The state share of payments for services a provided under the waiver is made entirely from state funds appropriated by the Pennsylvania General Assembly. The state funds are derived from the tobacco litigation settlement proceeds, lottery funds and general revenue sources. The state does not use provider tax revenues to fund the state share of payments for waiver services.

## 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:

Pursuant to 42 CFR 441.310 (a) (2), the Department will only reimburse service providers for room and board costs when respite services are provided in Medicaid Certified Nursing Facilities.

Reimbursement for room and board costs when respite services are provided in private residences are excluded under the Aging Waiver. The Aging Waiver does not provide residential services. Participants may receive Personal Assistance Services in their home or the home of a friend family member.

The PROMISe MMIS system completes an authorization of individual's eligibility for services within the waiver. Waiver services, other than per diem respite, cannot be billed when an individual is in a facility.

Single Audit protocols include review for the room and board exclusion.

## 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: Nursing Facility**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 17592.17 | 2103.00 | 19695.17 | 58835.74 | 1704.83 | 60540.57 | 40845.40 |
| 2 | 19842.90 | 1977.00 | 21819.90 | 44916.00 | 2275.00 | 47191.00 | 25371.10 |
| 3 | 20729.80 | 2143.74 | 22873.54 | 58835.74 | 1737.85 | 60573.59 | 37700.05 |
| 4 | 21145.74 | 2164.11 | 23309.85 | 58835.74 | 1754.36 | 60590.10 | 37280.25 |
| 5 | 21563.37 | 2184.47 | 23747.84 | 58835.74 | 1770.87 | 60606.61 | 36858.77 |

## 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: |
| | | Nursing Facility |
| Year 1 | 30000 | 30000 |
| Year 2 | 35806 | 35806 |
| Year 3 | 36421 | 36421 |
| Year 4 | 38891 | 38891 |
| Year 5 | 41361 | 41361 |

## 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.

Historically, the average length of stay for this waiver demonstrates an unpredictable pattern from year to year as demonstrated by submitted CMS 372's. In order to make a best estimate of the average length of stay for this renewal, OLTL reviewed the 372 reports for state fiscal years 2008-2009 through 2012-2013 and then projected forward through the five year waiver renewal period utilizing a

computerized (regression trend) forecast. This projected average length of stay for the five year period is stated in each table below. The length of stay data projection was calculated utilizing data from DPW's MMIS system, PROMISe and Client Information System (CIS). Specifically, paid claims with a last date of service were obtained from PROMISe and waiver eligibility segments were obtained from CIS for the 5 year period as noted above. This same data is used to calculate and report the actual average length of stay on the CMS 372's.

The unduplicated participants in Year 3 appear to increase by at least 30 percent compared to Year 2 and increases by at least 6% in Years 4 and 5. This increase is at least 19 percent more than the most recent CMS 372 report. Please explain how the state generated this estimate and why the numbers of unduplicated participants were increased.

Historical 372 reports submitted during a time most relevant to OLTL's current waiver program policy were analyzed to determine the average change that occurred in the count of unduplicated waiver recipients from SFY08/09 through SFY13/14. This recipient rate of change (count) was then added to the previous year's count of recipients to project unduplicated recipient counts for future years. The data reflects an increase. Please note only years 3, 4, and 5 were updated. Year 2 was not updated to reflect increases from what was originally submitted hence an increase of 30% is reflected.

## 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:

Factor D is calculated as follows:

Column 1 (Unit) – defines the unit of service for each service.

Column 2 (# Users) – Previously submitted 372 reports from Fiscal Years 2008/09, 2009/10, 2010/11, 2011/12 and 2012/13 were analyzed in combination with more recent Enterprise Data Warehouse (EDW) claim data pulled from July 1st 2013 through January 31st 2015. EDW claim data mirrors source data used for submitting OLTL's past CMS 372 reports.

EDW pulled claim data were parsed for State Fiscal Year (SFY) 2013/14 (between July 1st 2013 and June 30th 2014) and queried to obtain 372 reporting information. (Total Expenditures and Unduplicated Recipient Count). An average cost per user (Factor D) was then derived for SFY 2013/14. Note: Total Units and Average Total Units were also obtained.

Additionally, EDW claim data pulled between July 1st 2014 and January 31st 2015 were used to project total waiver expenditures for SFY 2014/15. i.e. – Total expenditures were divided by count of months to date (7) then multiplied by total number of months in a year (12).

The previously mentioned 372 reports were analyzed to determine the average change that occurred from SFY to SFY in the count of unduplicated waiver recipients. This recipient rate of change count was then added to the previous year's count of recipients to project unduplicated recipient counts for future years.

Column 3 (Avg. Units Per User) – EDW claims data pulled for SFY 2013-14 includes the number of units used in association with each paid claim. Using SFY 2013/14 data, an average units per person was calculated by dividing the total number of units by the number of unduplicated recipients for each service category associated with OLTL's renewed (or amended) waiver application. The average unit per person by service category derived from SFY13/14 data was then multiplied by the projected number of unduplicated users for each service category to obtain the units (per service category) for each estimated year. Note: A percent of users serviced ratio for each service category derived from SFY 2013/14 data was applied to the future years to obtain proportionate unduplicated users counts for each service category.

Column 5 (Component Cost) – An aggregate level cost is derived by multiplying the previous year's average cost per person by the estimated users previously described for Column 2 (above). At the service category level a weighted average of service category expenditures against the total waiver expenditures is applied.

Column 4 (Avg. Cost/Unit) – Is derived by dividing the estimated units (Column 1) by the total cost (Column 5) for each service category.

In this amendment, OLTL removed the "Accessibility Adaptations, Equipment, Technology and Medical Supplies" service definition, and created four new discreet service definitions – Home Adaptations, Vehicle Modifications, Assistive Technology and Specialized Medical Equipment and Supplies. In addition, OLTL has added a half-day unit of service for Adult Daily Living – Enhanced. "Placeholders" were used for these new service definitions and unit of service due to a lack of historical data or claims history. The estimates for future waiver years will be reviewed and modified as appropriate once data is made available.

Estimated Unduplicated Users for years 1 through 5 are used to derive users, average units per user, and average cost per unit by applying basic calculation against the most recent service data available(i.e. – SFY13-14).

The calculations for Average units per user and average cost per unit are as follows:

Average units per user = Estimate Unduplicated Users (At each service level) * Actual Average Units Per Person for FY13-14 (At each service level)

Average cost per unit = Estimate Unduplicated Users (At each service level) * Actual Average cost per unit for FY13-14 (At each service level)

Each year Actual Average cost per unit for FY13-14 (At each service level) and the Actual Average Units Per Person for FY13-14 (At each service level) will be updated to reflect updated data. i.e. – FY14/15. An amendment may be submitted to update our estimates respectively. An amendment will likely be submitted to update our estimates respectively each year.

Factor D Year 3 appears to increase by at least 29 percent compared to Year 2 and increases by at least 8 percent in Years 4 and 5. It is also 15 percent more than the most recent CMS 372 report. Please describe how the state generated this number and please provided backup documentation.

Total Estimated Expenditure = (The "Average Cost Per User" for the previous year * Estimated Unduplicated User) * 1.02 (or 2% for Inflationary Costs). Note: Please see previous question - chart number 2 – Estimated Unduplicated User.

Factor D = Total Estimated Expenditures / Estimated Unduplicated User

Note: The 2% was added to both sides of our neutrality equation (Factor D and G) to better align with current projection models used by our Office of Finance.

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:

In calculating Factor D' - Derivation previously submitted 372 reports from SFY 2008/09 through SFY 2012/13 were analyzed. The Acute Care data while in a Home and Community Based Setting from the five year period specified above was then projected forward for the renewal period by dividing acute care costs by unduplicated participants and utilizing a computerized forecasting tool. For Factor D' a great deal of consideration was giving to future policy and programmatic changes resulting in a flattening of our projections.

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:

The G factor was formulated based on date from DPW's MMIS system, PROMISe. Paid claims to nursing facilities for the period of SFY 2010-11 for individuals age 60 and above were pulled from PROMISe and analyzed to determine an average daily rate. This rate was then annualized to determine the G factor. For the five year period prior to this SFY, nursing facility rates had remained relatively flat and it is anticipated that this will continue over the five year renewal period due to both transitioning initiatives and economic drivers.

OLTL cannot find the back-up calculations for this waiver, and the staff person responsible for these calculations retired a couple years ago. OLTL believes that five years is a typical sample size for trend analysis, but welcomes recommendations from CMS on a more reliable forecasting model.

Unfortunately, OLTL can't describe how the experience from the 372 reports was used to develop the number of users and average units per user for each of the waiver service/components for each of the waiver years.

OLTL plans to submit another addendum next year for appendix J. Currently, OLTL cannot use actual experience as reported via the CMS-372(s) as a trend baseline because in the past estimates, not actuals were submitted (disclosed in comments) and approved by CMS for Factor G and G'. CMS instructed OLTL (Spring 2013) for SFY 2011-12 reporting to stop using estimates and use actual data for G and G'. Regrettably, our estimates for G & G' for SFY 2010-11 and earlier proved to be significantly askew.

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:

G' factor was formulated by reviewing paid claims data for SFY 2010-2011 obtained from PROMISe, DPW's MMIS system, for persons age 60 and older utilizing nursing facility services who also had acute care paid claims including the deduction of Medicare Part D drug costs. This estimate was then projected forward for the renewal period by dividing acute care costs by unduplicated nursing facility residents and utilizing a computerized forecasting tool.

## 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 Services** |
| **Personal Assistance Services** |
| **Respite** |
| **Service Coordination** |
| **Home Health Services** |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies** |
| **Assistive Technology** |
| **Community Transition Services** |
| **Home Adaptations** |
| **Home Delivered Meals** |
| **Non-Medical Transportation** |
| **Participant-Directed Community Supports** |
| **Participant-Directed Goods and Services** |
| **Personal Emergency Response Service (PERS)** |
| **Specialized Medical Equipment and Supplies** |
| **TeleCare** |
| **Therapeutic and Counseling Services** |

## 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 Services Total:** | | | | | | **24343317.44** |
| Adult Daily Living Services | Full Day | 361 | 112.00 | 64.19 | **2595330.08** | |
| Adult Daily Living Services - Half Day | Half Day | 54 | 21.00 | 31.24 | **35426.16** | |
| Adult Daily Living Services - Enhanced | Full Day | 2277 | 124.00 | 76.90 | **21712561.20** | |
| Adult Daily Living Services - Enhanced Half Day | Half Day | 0 | 0.00 | 1.10 | **0.00** | |
| **Personal Assistance Services Total:** | | | | | | **438397360.44** |
| Personal Assistance - Agency | 15 Min | 19916 | 3403.00 | 4.59 | **311083339.32** | |
| Personal Assistance - Participant Directed | 15 Min | 8272 | 4933.00 | 3.12 | **127314021.12** | |
| **Respite Total:** | | | | | | **1609412.17** |
| Respite - In Home Agency | 15 Min | 227 | 690.00 | 4.27 | **668810.10** | |
| Respite - In Home Participant Directed | 15 min | 7 | 1021.00 | 3.01 | **21512.47** | |
| Respite - LTC Facility | Per diem | 440 | 13.00 | 160.68 | **919089.60** | |
| **Service Coordination Total:** | | | | | | **37400411.50** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Service Coordination | 15 Min | 29350 | 61.00 | 20.89 | **37400411.50** | |
| **Home Health Services Total:** | | | | | | **2006878.70** |
| Home Health Aide | 15 Min | 18 | 616.00 | 6.11 | **67747.68** | |
| Physical Therapy | 15 Min | 272 | 9.00 | 13.80 | **33782.40** | |
| Nursing - RN | 15 Min | 814 | 92.00 | 13.47 | **1008741.36** | |
| Speech Therapy | 15 Min | 3 | 95.00 | 21.72 | **6190.20** | |
| Occupational Therapy | 15 Min | 218 | 7.00 | 18.31 | **27941.06** | |
| Nursing - LPN | 15 Min | 535 | 192.00 | 8.05 | **826896.00** | |
| Physical Therapy Assistant | 15 Min | 15 | 100.00 | 11.86 | **17790.00** | |
| Occupational Therapy Assistant | 15 Min | 15 | 100.00 | 11.86 | **17790.00** | |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:** | | | | | | **7810480.85** |
| Adaptation | Per Purchase | 1335 | 1.00 | 2579.71 | **3443912.85** | |
| Equipment | Per Purchase | 7477 | 5.00 | 116.80 | **4366568.00** | |
| **Assistive Technology Total:** | | | | | | **0.00** |
| Assistive Technology | Per Purchase | 0 | 0.00 | 1095.42 | **0.00** | |
| **Community Transition Services Total:** | | | | | | **115800.88** |
| Community Transition Services | One Time | 52 | 2.00 | 1113.47 | **115800.88** | |
| **Home Adaptations Total:** | | | | | | **0.00** |
| Home Adaptations | Per Adaptation | 0 | 0.00 | 2938.91 | **0.00** | |
| **Home Delivered Meals Total:** | | | | | | **9092709.60** |
| Meal | Meal | 8161 | 195.00 | 5.44 | **8657188.80** | |
| Sandwich | Sandwich | 705 | 143.00 | 4.32 | **435520.80** | |
| **Non-Medical Transportation Total:** | | | | | | **2231243.34** |
| Non-Medical Transportation | Per Trip | 1978 | 57.00 | 19.79 | **2231243.34** | |
| **Participant-Directed Community Supports Total:** | | | | | | **726418.00** |
| Participant-Directed Community Supports | Per Purchase | 28 | 10.00 | 2594.35 | **726418.00** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **7192.24** |
| Participant-Directed Goods and Services | Per Purchase | 8 | 1.00 | 899.03 | **7192.24** | |
| **Personal Emergency Response Service (PERS) Total:** | | | | | | **3463063.11** |
| Personal Emergency Response | Per Purchase | 14183 | 9.00 | 27.13 | **3463063.11** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **0.00** |
| Specialized Medical Equipment and Supplies | Per Purchase | 0 | 0.00 | 123.93 | **0.00** | |
| **TeleCare Total:** | | | | | | **284539.02** |
| Health Status Measuring and Monitoring DME | Per Purchase | 8 | 1.00 | 1080.00 | **8640.00** | |
| Health Status Measuring and Monitoring | Per Day | | | | **666.00** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Ongoing | | 4 | 5.00 | 33.30 | | |
| Health Status Measuring and Monitoring Remote | Per Purchase | 41 | 185.00 | 10.14 | **76911.90** | |
| Health Status Measuring and Monitoring Set-Up | One Time | 3 | 1.00 | 90.00 | **270.00** | |
| Activity and Sensor Monitoring Set-Up | One Time | 3 | 1.00 | 90.00 | **270.00** | |
| Activity and Sensor Monitoring Ongoing | Monthly | 6 | 8.00 | 80.00 | **3840.00** | |
| Medication Dispensing and Monitoring | Monthly | 498 | 8.00 | 48.68 | **193941.12** | |
| **Therapeutic and Counseling Services Total:** | | | | | | **276353.28** |
| Counseling | 15 min | 249 | 84.00 | 11.83 | **247436.28** | |
| Nutritional Counseling | 15 min | 25 | 84.00 | 13.77 | **28917.00** | |
| | | **GRAND TOTAL:** | | | | **527765180.57** |
| | | **Total Estimated Unduplicated Participants:** | | | | **30000** |
| | | **Factor D (Divide total by number of participants):** | | | | **17592.17** |
| | | **Average Length of Stay on the Waiver:** | | | | 275 |

## 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 Services Total:** | | | | | | **28538481.91** |
| Adult Daily Living Services | Full Day | 384 | 107.02 | 64.12 | **2635055.00** | |
| Adult Daily Living Services - Half Day | Half Day | 31 | 24.70 | 33.47 | **25627.98** | |
| Adult Daily Living Services - Enhanced | Full Day | 2576 | 128.02 | 78.47 | **25877798.93** | |
| Adult Daily Living Services - Enhanced Half Day | Half Day | 0 | 0.00 | 1.10 | **0.00** | |
| **Personal Assistance Services Total:** | | | | | | **603786685.25** |
| Personal Assistance - Agency | 15 Min | 24733 | 3637.54 | 5.21 | **468729512.23** | |
| Personal Assistance - Participant Directed | 15 Min | 7395 | 5324.58 | 3.43 | **135057173.01** | |
| **Respite Total:** | | | | | | **1554769.17** |
| Respite - In Home Agency | 15 Min | 185 | 552.95 | 5.58 | **570810.28** | |
| Respite - In Home Participant Directed | 15 Min | 17 | 692.53 | 5.51 | **64869.29** | |
| Respite - LTC Facility | Per diem | 440 | 13.00 | 160.68 | **919089.60** | |
| **Service Coordination Total:** | | | | | | **41739826.88** |
| Service Coordination | 15 Min | 34140 | 62.73 | 19.49 | **41739826.88** | |
| **Home Health Services Total:** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | **3145098.96** |
| Home Health Aide | 15 Min | 7 | 1124.00 | 5.57 | **43824.76** | |
| Physical Therapy | 15 Min | 246 | 6.94 | 21.18 | **36159.34** | |
| Nursing - RN | 15 Min | 919 | 76.44 | 17.31 | **1215999.11** | |
| Speech Therapy | 15 Min | 2 | 125.50 | 22.80 | **5722.80** | |
| Occupational Therapy | 15 Min | 341 | 6.66 | 21.97 | **49895.19** | |
| Nursing - LPN | 15 Min | 671 | 158.60 | 16.80 | **1787866.08** | |
| Physical Therapy Assistant | 15 Min | 36 | 8.00 | 11.51 | **3314.88** | |
| Occupational Therapy Assistant | 15 Min | 20 | 8.00 | 14.48 | **2316.80** | |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:** | | | | | | **10684054.07** |
| Adaptation | Per Purchase | 1546 | 1.16 | 2815.85 | **5049832.76** | |
| Equipment | Per Purchase | 8643 | 5.49 | 118.74 | **5634221.31** | |
| **Assistive Technology Total:** | | | | | | **0.00** |
| Assistive Technology | Purchase | 0 | 0.00 | 1095.42 | **0.00** | |
| **Community Transition Services Total:** | | | | | | **90029.46** |
| Community Transition Services | One Time | 43 | 1.61 | 1300.44 | **90029.46** | |
| **Home Adaptations Total:** | | | | | | **0.00** |
| Home Adaptations | Adaptation | 0 | 0.00 | 2938.91 | **0.00** | |
| **Home Delivered Meals Total:** | | | | | | **12677933.35** |
| Meal | Meal | 10003 | 216.89 | 5.61 | **12171179.26** | |
| Sandwich | Sandwich | 658 | 132.10 | 5.83 | **506754.09** | |
| **Non-Medical Transportation Total:** | | | | | | **2468930.43** |
| Non-Medical Transportation | Per Trip | 2084 | 57.65 | 20.55 | **2468930.43** | |
| **Participant-Directed Community Supports Total:** | | | | | | **952844.62** |
| Participant-Directed Community Supports | Per Purchase | 30 | 9.39 | 3382.48 | **952844.62** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **6953.10** |
| Participant-Directed Goods and Services | Per Purchase | 5 | 1.50 | 927.08 | **6953.10** | |
| **Personal Emergency Response Service (PERS) Total:** | | | | | | **4442108.79** |
| Personal Emergency Response | Per Purchase | 16829 | 9.08 | 29.07 | **4442108.79** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **0.00** |
| Specialized Medical Equipment and Supplies | Purchase | 0 | 0.00 | 123.93 | **0.00** | |
| **TeleCare Total:** | | | | | | **344346.90** |
| Health Status Measuring and Monitoring DME | Per Purchase | 11 | 1.00 | 1080.00 | **11880.00** | |
| Health Status Measuring and Monitoring Ongoing | Monthly | 59 | 148.00 | 10.00 | **87320.00** | |
| Health Status Measuring and Monitoring | Monthly | | | | **9036.90** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Remote | | 6 | 15.00 | 100.41 | | |
| Health Status Measuring and Monitoring Set-Up | One Time | 3 | 8.00 | 200.00 | **4800.00** | |
| Activity and Sensor Monitoring Set-Up | One Time | 3 | 1.00 | 90.00 | **270.00** | |
| Activity and Sensor Monitoring Ongoing | Monthly | 6 | 8.00 | 80.00 | **3840.00** | |
| Medication Dispensing and Monitoring | Monthly | 568 | 8.00 | 50.00 | **227200.00** | |
| **Therapeutic and Counseling Services Total:** | | | | | | **62695.90** |
| Counseling | 15 min | 55 | 74.94 | 12.41 | **51150.30** | |
| Nutritional Counseling | 15 min | 11 | 10.00 | 104.96 | **11545.60** | |
| | | **GRAND TOTAL:** | | | | **710494758.79** |
| | | **Total Estimated Unduplicated Participants:** | | | | **35806** |
| | | **Factor D (Divide total by number of participants):** | | | | **19842.90** |
| | | **Average Length of Stay on the Waiver:** | | | | 289 |

## 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 Services Total:** | | | | | | **30303315.04** |
| Adult Daily Living Services | Full Day | 390 | 107.02 | 66.92 | **2793093.58** | |
| Adult Daily Living Services - Half Day | Half Day | 31 | 24.70 | 34.93 | **26745.90** | |
| Adult Daily Living Services - Enhanced | Full Day | 2620 | 128.02 | 81.90 | **27470275.56** | |
| Adult Daily Living Services - Enhanced Half Day | Half Day | 12 | 1000.00 | 1.10 | **13200.00** | |
| **Personal Assistance Services Total:** | | | | | | **641216315.30** |
| Personal Assistance - Agency | 15 Min | 25158 | 3637.54 | 5.44 | **497831978.38** | |
| Personal Assistance - Participant Directed | 15 Min | 7522 | 5324.58 | 3.58 | **143384336.92** | |
| **Respite Total:** | | | | | | **2157339.83** |
| Respite - In Home Agency | 15 Min | 188 | 552.95 | 5.82 | **605015.77** | |
| Respite - In Home Participant Directed | 15 min | 17 | 692.53 | 5.75 | **67694.81** | |
| Respite - LTC Facility | Per diem | 511 | 13.46 | 215.85 | **1484629.25** | |
| **Service Coordination Total:** | | | | | | **44307882.67** |
| Service Coordination | 15 Min | 34726 | 62.73 | 20.34 | **44307882.67** | |
| **Home Health Services Total:** | | | | | | **3360321.97** |
| Home Health Aide | | | | | **45791.76** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 15 Min | 7 | 1124.00 | 5.82 | | |
| Physical Therapy | 15 Min | 251 | 6.94 | 22.11 | **38514.29** | |
| Nursing - RN | 15 Min | 935 | 76.44 | 18.06 | **1290773.48** | |
| Speech Therapy | 15 Min | 2 | 125.50 | 23.79 | **5971.29** | |
| Occupational Therapy | 15 Min | 347 | 6.66 | 22.93 | **52991.69** | |
| Nursing - LPN | 15 Min | 683 | 158.60 | 17.54 | **1899999.45** | |
| Physical Therapy Assistant | 15 Min | 12 | 100.00 | 10.95 | **13140.00** | |
| Occupational Therapy Assistant | 15 Min | 12 | 100.00 | 10.95 | **13140.00** | |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:** | | | | | | **0.00** |
| Adaptation | Per Purchase | 0 | 0.00 | 2938.86 | **0.00** | |
| Equipment | Per Purchase | 0 | 0.00 | 123.93 | **0.00** | |
| **Assistive Technology Total:** | | | | | | **13145.04** |
| Assistive Technology | Purchase | 12 | 1.00 | 1095.42 | **13145.04** | |
| **Community Transition Services Total:** | | | | | | **96149.01** |
| Community Transition Services | One Time | 44 | 1.61 | 1357.27 | **96149.01** | |
| **Home Adaptations Total:** | | | | | | **5359161.16** |
| Home Adaptations | Adaptation | 1572 | 1.16 | 2938.91 | **5359161.16** | |
| **Home Delivered Meals Total:** | | | | | | **13447425.53** |
| Meal | Meal | 10175 | 216.89 | 5.85 | **12910106.14** | |
| Sandwich | Sandwich | 669 | 132.10 | 6.08 | **537319.39** | |
| **Non-Medical Transportation Total:** | | | | | | **2620353.92** |
| Non-Medical Transportation | Per Trip | 2120 | 57.65 | 21.44 | **2620353.92** | |
| **Participant-Directed Community Supports Total:** | | | | | | **994485.51** |
| Participant-Directed Community Supports | Per Purchase | 30 | 9.39 | 3530.30 | **994485.51** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **7256.93** |
| Participant-Directed Goods and Services | Per Purchase | 5 | 1.50 | 967.59 | **7256.92** | |
| **Personal Emergency Response Service (PERS) Total:** | | | | | | **4715789.89** |
| Personal Emergency Response | Per Purchase | 17118 | 9.08 | 30.34 | **4715789.89** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **5981863.15** |
| Specialized Medical Equipment and Supplies | Purchase | 8792 | 5.49 | 123.93 | **5981863.15** | |
| **TeleCare Total:** | | | | | | **352509.60** |
| Health Status Measuring and Monitoring DME | Per Purchase | 12 | 1.10 | 453.05 | **5980.26** | |
| Health Status Measuring and Monitoring Ongoing | Monthly | 43 | 167.35 | 10.95 | **78796.75** | |
| Health Status Measuring and Monitoring Remote | Monthly | 12 | 10.00 | 109.54 | **13144.80** | |
| Health Status Measuring and Monitoring Set- | One Time | | | | **219.08** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Up | | 1 | 1.00 | 219.08 | | |
| Activity and Sensor Monitoring Set-Up | One Time | 12 | 10.00 | 109.54 | **13144.80** | |
| Activity and Sensor Monitoring Ongoing | Monthly | 3 | 6.00 | 50.27 | **904.86** | |
| Medication Dispensing and Monitoring | Monthly | 613 | 7.58 | 51.72 | **240319.05** | |
| **Therapeutic and Counseling Services Total:** | | | | | | **66562.03** |
| Counseling | 15 min | 55 | 74.94 | 12.96 | **53417.23** | |
| Nutritional Counseling | 15 min | 12 | 10.00 | 109.54 | **13144.80** | |
| | | | | **GRAND TOTAL:** | | **754999876.58** |
| | | | | **Total Estimated Unduplicated Participants:** | | **36421** |
| | | | | **Factor D (Divide total by number of participants):** | | **20729.80** |
| | | | | **Average Length of Stay on the Waiver:** | | 291 |

## 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 Services Total:** | | | | | | **33009186.90** |
| Adult Daily Living Services | Full Day | 417 | 107.02 | 68.26 | **3046262.23** | |
| Adult Daily Living Services - Half Day | Half Day | 33 | 24.70 | 35.63 | **29042.01** | |
| Adult Daily Living Services - Enhanced | Full Day | 2798 | 128.02 | 83.53 | **29920442.66** | |
| Adult Daily Living Services - Enhanced Half Day | Half Day | 12 | 1000.00 | 1.12 | **13440.00** | |
| **Personal Assistance Services Total:** | | | | | | **698439400.75** |
| Personal Assistance - Agency | 15 Min | 26864 | 3637.54 | 5.55 | **542339753.81** | |
| Personal Assistance - Participant Directed | 15 Min | 8032 | 5324.58 | 3.65 | **156099646.94** | |
| **Respite Total:** | | | | | | **2352528.06** |
| Respite - In Home Agency | 15 Min | 201 | 552.95 | 5.94 | **660189.12** | |
| Respite - In Home Participant Directed | 15 min | 19 | 692.53 | 5.87 | **77237.87** | |
| Respite - LTC Facility | Per diem | 545 | 13.46 | 220.17 | **1615101.07** | |
| **Service Coordination Total:** | | | | | | **48266390.95** |
| Service Coordination | 15 Min | 37081 | 62.73 | 20.75 | **48266390.95** | |
| **Home Health Services Total:** | | | | | | **3653538.53** |
| Home Health Aide | 15 Min | 7 | 1124.00 | 5.93 | **46657.24** | |
| Physical Therapy | | | | | **41941.20** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 15 Min | 268 | 6.94 | 22.55 | | |
| Nursing - RN | 15 Min | 998 | 76.44 | 18.43 | **1405971.62** | |
| Speech Therapy | 15 Min | 2 | 125.50 | 24.27 | **6091.77** | |
| Occupational Therapy | 15 Min | 370 | 6.66 | 23.39 | **57637.64** | |
| Nursing - LPN | 15 Min | 729 | 158.60 | 17.89 | **2068431.07** | |
| Physical Therapy Assistant | 15 Min | 12 | 100.00 | 11.17 | **13404.00** | |
| Occupational Therapy Assistant | 15 Min | 12 | 100.00 | 11.17 | **13404.00** | |
| **Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:** | | | | | | **0.00** |
| Adaptation | Per Purchase | 0 | 0.00 | 894.22 | **0.00** | |
| Equipment | Per Purchase | 0 | 0.00 | 122.51 | **0.00** | |
| **Assistive Technology Total:** | | | | | | **13407.96** |
| Assistive Technology | Purchase | 12 | 1.00 | 1117.33 | **13407.96** | |
| **Community Transition Services Total:** | | | | | | **104758.30** |
| Community Transition Services | One Time | 47 | 1.61 | 1384.41 | **104758.30** | |
| **Home Adaptations Total:** | | | | | | **5838420.95** |
| Home Adaptations | Adaptation | 1679 | 1.16 | 2997.69 | **5838420.95** | |
| **Home Delivered Meals Total:** | | | | | | **14653144.08** |
| Meal | Meal | 10865 | 216.89 | 5.97 | **14068363.80** | |
| Sandwich | Sandwich | 714 | 132.10 | 6.20 | **584780.28** | |
| **Non-Medical Transportation Total:** | | | | | | **2854463.65** |
| Non-Medical Transportation | Per Trip | 2264 | 57.65 | 21.87 | **2854463.65** | |
| **Participant-Directed Community Supports Total:** | | | | | | **1081998.43** |
| Participant-Directed Community Supports | Per Purchase | 32 | 9.39 | 3600.90 | **1081998.43** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **7402.05** |
| Participant-Directed Goods and Services | Per Purchase | 5 | 1.50 | 986.94 | **7402.05** | |
| **Personal Emergency Response Service (PERS) Total:** | | | | | | **5135214.52** |
| Personal Emergency Response | Per Purchase | 18279 | 9.08 | 30.94 | **5135214.52** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **6515186.57** |
| Specialized Medical Equipment and Supplies | Purchase | 9388 | 5.49 | 126.41 | **6515186.57** | |
| **TeleCare Total:** | | | | | | **382255.25** |
| Health Status Measuring and Monitoring DME | Per Purchase | 12 | 1.10 | 462.11 | **6099.85** | |
| Health Status Measuring and Monitoring Ongoing | Monthly | 46 | 167.35 | 11.17 | **85987.78** | |
| Health Status Measuring and Monitoring Remote | Monthly | 12 | 10.00 | 111.73 | **13407.60** | |
| Health Status Measuring and Monitoring Set-Up | One Time | 1 | 1.00 | 223.47 | **223.47** | |
| Activity and Sensor Monitoring Set-Up | One Time | | | | **13407.60** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 12 | 10.00 | 111.73 | | |
| Activity and Sensor Monitoring Ongoing | Monthly | 4 | 6.00 | 51.27 | **1230.48** | |
| Medication Dispensing and Monitoring | Monthly | 655 | 7.58 | 52.75 | **261898.48** | |
| **Therapeutic and Counseling Services Total:** | | | | | | **71815.09** |
| Counseling | 15 min | 59 | 74.94 | 13.21 | **58407.49** | |
| Nutritional Counseling | 15 min | 12 | 10.00 | 111.73 | **13407.60** | |
| | | **GRAND TOTAL:** | | | | **822379112.06** |
| | | **Total Estimated Unduplicated Participants:** | | | | **38891** |
| | | **Factor D (Divide total by number of participants):** | | | | **21145.74** |
| | | **Average Length of Stay on the Waiver:** | | | | 292 |

## 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**