

Appendix B: Participant Access and Eligibility

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

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

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="radio"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input type="radio"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input checked="" type="checkbox"/> Aged (age 65 and older)	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Disabled (Physical) (under age 65)	60	64	
	<input type="checkbox"/> Disabled (Other) (under age 65)			
<input type="radio"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/> Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness (<i>check each that applies</i>)			
	<input type="checkbox"/> Mental Illness (age 18 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Mental Illness (under age 18)			

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

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- 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*):

<input type="radio"/>	Not applicable – There is no maximum age limit
<input checked="" type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit (<i>specify</i>): 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.

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Appendix B-2: Individual Cost Limit

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

<input checked="" type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>			
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	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. <i>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.</i>		
<input type="radio"/>			
<input type="radio"/>	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
<input type="radio"/>	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>			
<input type="radio"/>	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.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		

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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:

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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*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	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:
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

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

Table B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	30,363
Year 2	35,806
Year 3	36,421
Year 4 (renewal only)	38,891
Year 5 (renewal only)	41,361

- 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)*:

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	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	22,500
Year 2	27,956
Year 3	28,105
Year 4 (renewal only)	29,035
Year 5 (renewal only)	30,966

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- 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*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.	
<input checked="" type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	Money Follows the Person rebalancing demonstration	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
	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. Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.	
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1	241	
Year 2	365	
Year 3	422	
Year 4 (renewal only)	479	
Year 5 (renewal only)	536	

- 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*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.** *Select one:*

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●	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:

<p>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:</p> <ol style="list-style-type: none"> 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.
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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

a-2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State.

<input type="radio"/>	Yes
<input checked="" type="radio"/>	No

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

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
✓	Low income families with children as provided in §1931 of the Act
✓	SSI recipients
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
✓	Optional State supplement recipients
✓	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
●	100% of the Federal poverty level (FPL)
○	% of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
✓	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
✓	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐	Medically needy in 209(b) States (42 CFR §435.330)
✓	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
✓	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
	All other mandatory and optional groups under the State Plan are included.

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Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
<input type="radio"/>	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.
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	A special income level equal to (select one):
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of FBR, which is lower than 300% (42 CFR §435.236)
<input type="radio"/>	\$ which is lower than 300%
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of FPL
<input type="radio"/>	% of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :

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Appendix B-5: Post-Eligibility Treatment of Income

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

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

<input checked="" type="radio"/>	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 (<i>select one</i>):
<input checked="" type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	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. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

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

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input checked="" type="radio"/>	The following standard included under the State plan (<i>select one</i>):
<input type="radio"/>	SSI standard
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input checked="" type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300%.
<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):
<input type="radio"/>	

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify):		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>)		
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. <i>Select one:</i>			
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>		
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):		

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

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

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iii. Allowance for the family <i>(select one)</i>	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable <i>(see instructions)</i>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable <i>(see instructions)</i> Note: <i>If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>(specify)</i> : <input type="text"/>

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>	
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>
<input type="radio"/>	SSI standard
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i> :
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)

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<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300%.
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (see instructions)	
iii. Allowance for the family (select one):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (see instructions)	

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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. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
	<input type="radio"/>	The following standard under 42 CFR §435.121:	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)	
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of the FBR, which is less than 300%
	<input type="radio"/>	\$	which is less than 300% of the FBR
	<input type="radio"/>	%	of the Federal poverty level
	<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):	
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (<i>specify</i>):		

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ii. Allowance for the spouse only (<i>select one</i>):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one</i> :		
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):	

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

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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 (<i>select one</i>):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input checked="" type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (<i>specify</i>):	
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. <i>Select one:</i>		
<input checked="" type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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Appendix B-6: Evaluation/Reevaluation of Level of Care

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

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

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is (<i>insert number</i>):
	2
ii.	Frequency of services. The State requires (<i>select one</i>):
<input checked="" type="radio"/>	The provision of waiver services at least monthly
<input type="radio"/>	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*):

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input checked="" type="radio"/>	Other (<i>specify</i>):
	The local Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. In addition a physician (M.D or D.O) completes a level of care recommendation utilizing the physician certification form.
	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:

<u>AAA Assessors must meet the following qualifications:</u>	
One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent	

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combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences OR

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

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

Any equivalent combination of experience or training including successful completion of 12 semester credit hours of college level courses in sociology, social welfare, psychology, gerontology or other related social sciences. One year experience in the AAA system may be substituted for one year assessment experience.

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

Physicians

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

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

The applicant's physician is responsible for completing the physician's certification form. OLTL does not contract directly with physicians to perform participant evaluations. When an individual is applying for services, the IEB sends a physician certification form and cover letter with an explanation of the application for home and community-based services to the applicant's primary care physician. The physician will indicate the applicant's level of care and return it to the IEB. The physician certification form includes:

- Physician's recommendation of level of care required
- Diagnoses
- ICD-10 code(s)
- Length of care required - short-term (180 days or less) or long-term (over 180 days)
- Physician's signature, license number and contact information.

- 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, an individual should be considered NFCE if:

1. The individual has an illness, injury, disability or medical condition diagnosed by a physician; and

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2. As a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; 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 Clinical Eligibility Determination 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*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	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 applicant first applies for Aging Waiver services through the statewide Independent Enrollment Broker (IEB). The role of the IEB is to facilitate and support the participant through the enrollment process including the level of care evaluation.
- The IEB makes a referral to the local AAA for the clinical eligibility determination and assists the applicant with obtaining a completed physician certification form from the applicant's physician (M.D. or D.O.)
- The local AAA visits the applicant within 15 days of receiving the referral from the IEB, and uses the standardized level of care determination tool to identify information regarding the applicant's medical status, recent hospitalizations, and functional ability (ADLs and IADLs). The standardized level of care determination tool is used in all 67 counties for all individuals entering a home and community-based waiver, LIFE and to determine institutional level of care.
- The physician completes the physician certification form indicating the applicant's diagnosis and the physician's clinical eligibility recommendation. Once complete, the IEB forwards the physician's certification form to the local AAA.

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- The IEB follows the status of the clinical eligibility determination process and assists with any required communication between the applicant, the applicant’s physician, and the AAA.
- The local AAA is responsible for making the final clinical eligibility decision subject to OLTL oversight.

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

- The local AAA is responsible for completion of the annual redetermination of level of care.
- The AAA assessor visits the participant and uses the standardized level of care determination 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 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- 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 standardized level of care determination 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.

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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.

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Appendix B-7: Freedom of Choice

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

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

PARTICIPANT FREEDOM OF CHOICE

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

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

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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.

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

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

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 contract with the Independent Enrollment Broker (IEB) requires the IEB 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 be 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.

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