

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Department of Human Services, Office of Long-Term Living
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Submission Date:	December 30, 2016
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CMS Receipt Date (CMS Use)	
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Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:

The Aging waiver provides home and community-based services to persons 60 and over who meet the Nursing Facility level of care. The Aging waiver 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

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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.

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1. Request Information

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

B. Waiver Title (optional): **Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver)**

C. Type of Request (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="radio"/>	Renewal (5 Years) of Waiver #		
<input checked="" type="radio"/>	Amendment to Waiver #	0279	

D. Type of Waiver (select only one):

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: **April 1, 2017**

E.2 Approved Effective Date (CMS Use):

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

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	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:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (select applicable level of care)
<input checked="" type="radio"/>	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:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.</i>		
<input type="checkbox"/>	A program authorized under §1915(i) of the Act		
<input type="checkbox"/>	A program authorized under §1915(j) of the Act		
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

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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 Human Services (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.

Participants access services through a statewide Independent Enrollment Broker (IEB) that assists individuals with enrollment into the waiver. Through the Title XIX Medicaid Waiver Grant Agreements with the local Area Agencies on Aging, OLTL contracts with fifty-two (52) local Area Agencies on Aging to perform the initial level of care determinations for potential Aging Waiver enrollees and the annual level of care reevaluations for Aging Waiver participants.

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.

Through this amendment, the Commonwealth proposes to:

- Add a Transition Plan for the transition of participants to Community HealthChoices (CHC).

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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*):

<input checked="" type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the overall systems improvement for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State’s demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

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

<input checked="" type="radio"/>	Yes (<i>complete remainder of item</i>)
<input type="radio"/>	No

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

<input checked="" type="checkbox"/>	<p>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. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
	<p>The commonwealth’s Department of Human Services (DHS) is embarking on a phase-in of a Managed Long-term Services and Supports (MLTSS) model of service delivery known as Community Health Choices (CHC). CHC will be rolled out in all 67 counties that comprise five (5) geographic zones based on the following schedule:</p> <ul style="list-style-type: none"> • July 1, 2017 implementation of CHC in the Southwestern zone (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Greene, Fayette, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties); • January 1, 2018 implementation of CHC in the Southeast zone (Bucks, Chester, Delaware, Philadelphia and Montgomery counties); • January 1, 2019 implementation of CHC in the remainder of the state. <p>Aging waiver participants will be transitioned from the Aging Waiver to the CHC waiver as described in Main Module, Attachment #1.</p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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,

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3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:

- (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and,
- (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic

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services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431Subpart 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.

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H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

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 Aging waiver-specific transition plan, and proposed changes included in the amendment.

Timeline:

Specifically in the drafting of the Aging waiver amendment and transition plan, the following strategies were undertaken:

- February 9, 2016 discussed at the Long – Term Care Subcommittee of the MAAC
- March 17, 2016 discussed on OLTL’s “Third Thursday” webinar, which provides a broad stakeholder audience updates on activities surrounding the implementation of Community HealthChoices
- March 30, 2016 discussed at the Consumer Subcommittee of the MAAC
- March 31, 2016 discussed at the Medical Assistance Advisory Committee
- April 1, 2016 distributed via the OLTL ListServ and posted on the OLTL website <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/2016AgingWaiverAmendment/index.htm#>
- April 1, 2016 distributed a separate email to all Service Coordination Entities with a prepared information sheet for participants
- April 2, 2016 Public Notice was published in the Pennsylvania Bulletin and distributed via email and in paper copy
- April 4, 2016 notification sent out to various stakeholders, including waiver participants, through the Policy Information Exchange, via email and paper newsletter
- April 6, 2016 discussed at the Managed Long-Term Services and Supports Subcommittee of the MAAC
- April 13 and April 19, 2016 hosted webinars for all interested stakeholders
- May 4, 2016 Comments were shared with the Managed Long-Term Services and Supports Subcommittee of the MAAC
- June 14, 2016 Comments were shared at the Long – Term Care Subcommittee of the MAAC

Participant involvement:

Both the Managed Long-Term Services and Supports and the Long-Term Care Subcommittees of the MAAC include 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

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information that is presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents. These committees are used as venues 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 amendment as follows. On April 1, 2016, OLTL distributed the public notice announcing the availability of the amendment documents via the OLTL ListServ and posted it on the OLTL website at <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/2016AgingWaiverAmendment/index.htm#s>. In addition, a Public Notice was published in the Pennsylvania Bulletin on April 2, 2016, which is distributed electronically and in paper format via subscription. The official public comment period ended on May 2, 2016. Tribal consultation is not required as there are no federally recognized tribes in the commonwealth.

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. Formal comments were received from those participating on the webinars; in addition, clarifying questions were asked and were responded to. Written feedback was also 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.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/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 as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

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Last Name	Allen
Title:	Deputy Secretary
Agency:	Department of Human Services, Office of Medical Assistance Programs
Address 1:	625 Forster Street
Address 2:	Room 515, Health & Welfare Building
City	Harrisburg
State	PA
Zip Code	17120
Telephone:	(717) 787-1870
E-mail	leallen@pa.gov
Fax Number	(717) 787-4639

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ Leesa Allen _____
State Medicaid Director or Designee

Date:

First Name:	Leesa
Last Name	Allen
Title:	Deputy Secretary
Agency:	Department of Human Services, Office of Medical Assistance Programs
Address 1:	625 Forster Street
Address 2:	Room 515, Health & Welfare Building
City	Harrisburg
State	PA
Zip Code	17120
Telephone:	(717) 787-1870
E-mail	leallen@pa.gov
Fax Number	(717) 787-4639

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Aging Waiver Transition to Community HealthChoices

The commonwealth’s Department of Human Services (DHS) is embarking on a phase-in of a Managed Long-term Services and Supports (MLTSS) model of service delivery known as Community Health Choices (CHC). CHC will be rolled out in all 67 counties that comprise five (5) geographic zones, and will serve the following Participants:

- Adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility.
- Dual Eligibles age 21 or older whether or not they need or receive LTSS.

The rollout of CHC is anticipated to begin in July 2017 in southwestern PA, in January 2018 in southeastern Pennsylvania and in January 2019 in the remainder of the state. DHS will be using one of its other Office of Long-Term Living (OLTL) waivers as the vehicle to consolidate all current OLTL 1915(c) waivers, with the exception of the OBRA Waiver, to one 1915(b)/(c) CHC waiver. The CHC Waiver will have a nursing facility (NFCE) level of care. The Aging 1915(c) Waiver will not be operated concurrently with the CHC 1915(b) Waiver.

The process for transitioning Aging Waiver participants to CHC waiver is as follows:

1. Beginning in January 2017, individuals enrolled in the Aging Waiver in the southwest area of the state will receive a pre-transition letter from the Office of Long-Term Living (OLTL) notifying them of the change to managed care.
2. The Service Coordinator is responsible for contacting each Aging Waiver participant within six months of the beginning of each CHC roll-out phase to educate them on CHC. SCs will be expected to make phone contacts, face to face visits or send letters as appropriate to meet the needs of the Aging Waiver participant. Service coordinators will be required to answer any questions participants and family members have about CHC and the transition process. OLTL will provide Service coordinators a document with key information about CHC to use in responding to questions from participants.
3. The Independent Enrollment Broker (IEB) will be available to participants for telephonic or face-to-face choice counseling to choose the best plan for their needs. DHS will automatically enroll participants into a CHC-MCO if the participant does not select a CHC-MCO on their own. Individuals will be assigned to plans that align with the way in which they are currently receiving their services, and will be based upon the following:
 - First, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP.
 - Second, if the Participant is transferring from Health Choices, and the HC-MCO is also contracted as CHC-MCO, and the Participant has not made a CHC-MCO selection, the Participant will be enrolled in the affiliated CHC-MCO.
 - Last, if a Participant is receiving HCBS and their primary care physician is contracted with a CHC-MCO, the Participant will be enrolled in that plan. Plan assignment will follow automatic assignment logic after these conditions are exhausted.

The auto-assignment process does not negate the Participant’s option to change his/her CHC-MCO.

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4. Once a recipient has chosen or is assigned to a managed care plan, DHS will notify the CHC-MCO of the new enrollee. Managed care plans are required to send new enrollees a Participant Handbook, and other written materials, with information on participant rights and protections and how to access services within five business days of the participant's date of enrollment.

Individuals transitioning from the Aging Waiver to the CHC waiver will not lose any services, and will have access to additional services if so indicated through the needs assessment process. CHC-MCOs are required to maintain continuity of care for all individuals transitioning to CHC from other programs. Individuals transitioning from the Aging Waiver to CHC will be able to keep their current individual service plan, services, and providers for 180 days or until a new Person-Centered Service Plan (PCSP) is developed and new services and providers are secured, whichever is later. The CHC continuity of care requirements will be outlined in the Program Requirements and Agreement signed between the CHC-MCOs and DHS.

The Aging Waiver will continue to operate in the fee-for-service counties until all participants are transitioned to CHC according to the MLTSS roll-out schedule noted in Main Module 4-c above. Effective July 1, 2017, there will be no new enrollments into the Aging Waiver in the fourteen counties that will make up the southwestern region of CHC.

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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.

OLTL's Updated Aging Waiver Transition Plan May, 2016

Overview

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. The Plan outlines four phases of activity:

- 1.) Identification of tasks that need to be accomplished
- 2.) Assessment of the settings in which HCBS waiver services are provided. Settings are expected to fall within four categories:
 - a. Those presumed to be fully compliant with HCBS characteristics
 - b. Those that may be compliant, or could be compliant with changes
 - c. Those presume non-HCBS but evidence may be presented to CMS for heightened scrutiny

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- d. Those that do not comply with HCBS characteristics
- 3.) Development of remediation strategies for those settings that are not in compliance, and
- 4.) Outline a public input process that will be used throughout the phases.

OLTL will change its own processes and protocols based on the rule’s requirements, will at regular intervals consistently monitor providers through a variety of mechanisms and will include stakeholder input throughout these ongoing activities. Any changes to the Transition Plan will be put out for public input and a variety of input venues will be used to ensure that participants, providers, advocates and the general public have an opportunity to express their views.

The state assures that the settings transition plan included waiver specific transition plan 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.

Introduction to the Aging Waiver:

The Aging Waiver serves individuals over the age of 60 who are nursing facility clinically eligible and financially eligible for MA waiver services.

The following services are available through the Aging Waiver:

- Assistive Technology
- Adult Daily Living Services
- Community Transition Services
- Home Adaptations
- Home Delivered Meals
- Home Health Services
- Non-Medical Transportation Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- TeleCare
- Nutritional Consultation
- Counseling Services

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.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>

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- 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 comment period was achieved according to the following schedule:

- October 13, 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.pa.gov/learnaboutdhs/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

*The Aging waiver transition plan was submitted to CMS on December 31, 2014. What follows is an updated transition plan that includes updated results of our assessment phase, additional stakeholder activity, and more detailed remediation steps.

The Aging waiver transition plan received additional stakeholder input when it was distributed with the required public notice period for the Statewide Transition Plan in accordance with the following schedule:

- January 8, 2016 the Statewide Transition Plan containing the Aging waiver transition plan was distributed via the OLTL ListServ and posted on the OLTL website
- January 9, 2016 Public Notice was published in the Pennsylvania Bulletin
- February 9, 2016 discussed the transition plan at the Long-Term Care Subcommittee of the MAAC
- January 22 and February 1, 2016 The Department of Human Services (DHS) hosted webinars for all interested stakeholders

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 Attendant Care Waiver participants.

OLTL held a Stakeholder Meeting on May 7, 2015 to discuss CMS’ Final Rule related to Home and Community Based settings. There were 35 attendees representing various associations, participants, advocates, providers, and Department of Human Services’ staff. Deputy Secretary Burnett provided information about the HCBS final rule. She also shared some examples of the approach of other states to the final rule. OLTL staff presented an overview of the HCBS final rule and preliminary data results

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of a provider self-survey that was issued in April, 2015. Stakeholder input was provided on what compliance would look like, how OLTL could become compliant, barriers to compliance and strategies for continued engagement and communication with stakeholders. Stakeholders overwhelmingly expressed that OLTL should be flexible in interpreting the rule (consumer advocates, however, disagreed). Overall, stakeholders felt that a “one size fits all” will not work, especially when evaluating providers. In addition, stakeholders believed that Person-Centered Planning should hold the most weight and be considered as the lynchpin moving forward with an approach to implement the rule. A summary report of the meeting can be found on our website at <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>.

Information and updates were provided to the LTC Sub-MAAC on August 11, 2015 and October 13, 2015. Additionally, OLTL Service Coordinators and direct service providers were asked to share information with 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.

ASSESSMENT - OLTL's assessment activities included a systematic review of policy documents, provider enrollment documents and service definitions, a review of licensing requirements, and development and implementation of a provider self-survey. Data from these activities will be assessed and provider settings will be preliminarily placed into four categories: (1) Setting is fully compliant; (2) Settings that are not compliant but will be able to come into compliance through the transition planning process (3) Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and (4) 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 a sample of settings that the surveys indicate are fully compliant. These activities will give OLTL a provider perspective on settings, which will be followed by official OLTL on-site monitoring's to validate survey responses. OLTL also intended to implement a participant review tool, but due to budgetary constraints was unable to do so during the assessment phase. OLTL plans to implement the participant review tool after the approval of the state budget. These procedures and steps are outlined in the remediation section.

Assessment Results

The majority of the Aging waiver services are provided in the private homes of individuals and it is, therefore, presumed that the settings compliant with the CMS Rule.

Systemic Review of Regulations, policies, and Service Definitions: OLTL has completed a review of state laws and regulations regarding the in-home setting. OLTL collaborated with the Bureau of Human Services Licensing (BHSL) and the Department of Aging (PDA) as applicable to identify settings that are licensed by each entity to determine compliance with the HCBS rule. The results of OLTL’s analysis can be found on the OLTL website here <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>.

Settings Review: OLTL issued a web-based provider self-survey to all HCBS providers for OLTL waivers, and made available to all providers a paper version of the survey to complete if the provider was unable to access the web-based survey. The Electronic Provider Self-Survey tool can be found here

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<http://questionpro.com/t/ALHsBZSEE4>. Providers were asked to complete a survey for each site location at which they provide waiver services. OLTL received 775 completed surveys by 431 distinct providers. At the time the survey was distributed, 1100 providers were enrolled to provide services for OLTL. The 431 respondents represent a 39% response rate of all enrolled OLTL HCBS providers. OLTL conducted follow-up activities with those providers that were identified as not completing and submitting the provider self-survey. OLTL compiled and analyzed data from the Provider Self-Surveys as they potentially conform to HCBS characteristics and their ability to comply in the future. The summary results of the survey, along with a copy of the survey can be found here <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>. OLTL coordinated with the Department of Aging to validate surveys submitted by Adult Daily Living settings, which are licensed and monitored through the Department of Aging. OLTL and the Department of Aging’s licensing staff reached out to those Adult Daily Living settings that did not return surveys and asked them to complete and submit a survey to OLTL.

Based on this review, OLTL preliminarily identified the settings that:

- (1) Yes, Setting is fully compliant;
- (2) Settings that are not compliant but will be able to come into compliance through the transition planning process
- (3) Not Yet. Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and
- (4) No. Setting does not comply.

Category 1

Services in settings that fully comply with the regulatory requirements because they are individually provided in the participant’s private home and allow the client full access to community living. These settings are Non-Residential service settings. Participants get to choose what service and supports they want to receive and who provides them. Participants are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.

Service Description

Assistive Technology: Assistive Technology is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that ensures the health, welfare and safety of the participant and increases, maintains or improves a participant’s functioning in communication, self-help, self-direction, life supports or adaptive capabilities.

Community Transition Services: 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.

Financial Management Services: Financial Management Services (FMS) include fiscal-related services to participants’ choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the participant’s individual service plan are managed and disbursed appropriately as authorized.

Home Adaptations: Home Adaptations are physical adaptations to the private residence of the participant to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home.

Home Delivered Meals: Home Delivered Meals provides meals to waiver participants who cannot

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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.

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

Non-Medical Transportation Services: Transportation services are services offered in order to enable individuals served on the waiver to gain access to waiver and other community activities and resources, specified by the plan of care/service plan.

Participant-Directed Community Supports: 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.

Participant-Directed Goods and Services: 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)

Personal Assistance Services: 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, and 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.

Personal Emergency Response System (PERS): PERS is an electronic device that enables an individual at high risk of institutionalization 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 the "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and would otherwise need extensive routine supervision.

Service Coordination: Service Coordination services are services that will assist individuals who receive waiver services in gaining access to needed waiver services and other State Medicaid Plan services, as

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well as medical, social, educational and other services regardless of the funding source. Service Coordination is working with and at the direction of the participant whenever possible to identify, coordinate, and facilitate waiver services.

Specialized Medical Equipment and Supplies: Specialized Medical Equipment and Supplies are devices, controls or appliances that enable participants to increase, maintain or improve their ability to perform activities of daily living.

Respite: 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. Respite Services furnished in a participant's home are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

TeleCare: 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.

Category 1

Services in settings that fully comply with the regulatory requirements because the participants travel to these settings from their private homes or residences and the settings serve non-Medicaid individuals. These settings allow the client full access to community living. Participants get to choose what service and supports they want to receive and who provides them. Participants are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.

Service Description

Adult Daily Living Services: 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.

Respite when provided in a NF (*This has been deemed allowable by CMS): 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 may also be provided in a long-term care facility on a per diem basis.

Therapeutic and Counseling Services (*Services may also be provided in the waiver participant's private home.): 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.

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Category 3

Not Yet. Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review. These settings are Non-residential settings. Participants receiving Adult Daily Living services leave their private home to attend the setting as described below in the current service definition. Older Adult Day settings are licensed by the Department of Aging under 6 Pa. Code 11. However, some Older Adult Day settings are located in a Nursing Facility.

Type of Setting: Older Adult Day settings licensed by the Department of Aging under 6 Pa. Code 11

Issue: Located on the grounds of a Nursing Facility

Number of Settings: 4

Service Setting Description: 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.

STILL UNDER ASSESSMENT

ASSESSMENT ACTIVITIES ARE STILL OCCURRING FOR THE FOLLOWING SETTINGS. OLTL QMET TEAMS ARE CURRENTLY CONDUCTING ON-SITE VISITS TO VALIDATE SURVEY RESULTS, GATHER FURTHER INFORMATION, AND OFFER TECHNICAL ASSISTANCE TO PROVIDERS. THE RESULTS OF THE ON-SITE VISITS WILL BE ANALYZED FOR IDENTIFICATION OF ISSUES THAT NEED ADDRESSED THROUGH DEVELOPMENT OF POLICY, PROCEDURES AND SERVICE DEFINITION CHANGES.

Type of Setting: DomCare

Issue: Lockable bedroom doors

Number of settings: 7

Service Setting Description: A premises certified by an Area Agency on Aging for the purpose of providing a supervised living arrangement in a homelike setting.

Provider owned housing where participants live and receive services from the provider.

Type of Setting: Unlicensed Provider Owned and Controlled Setting

Issue: Still under assessment

Number of settings: Still under assessment

Service Setting Description: Provider owned housing where participants live and receive services from the provider.

REMEDICATION STRATEGIES

1. Publication of Policy, Regulations, and Waiver Amendments/Renewals

The Pennsylvania Department of Human Services’ Office of Long-Term Living (OLTL) is developing a new managed long-term service and supports program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). The vision for CHC is an integrated system of physical health and long-term Medicare and Medicaid services that supports older adults and

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adults with physical disabilities to live safe and healthy lives with as much independence as possible, in the most integrated settings possible. The program will roll out in three phases, beginning in July 2017. The first phase in period is anticipated to begin on July 1, 2017 in the Southwest region of the state. The second phase in period will begin on January 1, 2018 in the Southeast region of the state, and the final phase in period will occur on January 1, 2019 for the remaining areas of the state.

As a result of the systemic assessment referenced above, OLTL discovered the need to set policy, procedures, and guidance for providers in order to more appropriately measure compliance. Therefore, in conjunction with the activities occurring with CHC and the CHC waiver application, OLTL will be working with stakeholders on the development of standards, policies, procedures and revised service definitions in order to more objectively measure characteristics of the HCBS Final Rule.

Publication of policy on Residential (Provider Owned and Controlled) settings: OLTL will work with stakeholders to develop and issue standards for residential settings in the HCBS waivers in the form of a policy.

Public Comment Target Date: May, 2016

Implementation Target Date: July, 2016

Publication of policy on Non-residential settings: OLTL will work with stakeholders to develop and issue standards for non-residential settings in the HCBS waivers in the form of a policy.

Public Comment Target Date: May, 2016

Implementation Target Date: July, 2016

Publication of policy on Individual Service Plan Documentation requirements: OLTL will issue policy on the documentation requirements for person-centered planning.

Public Comment Target Date: August, 2015

Implementation Target Date: December, 2015

Waiver Amendment/application to include Service Definition changes: OLTL will make revisions to service definitions and provider qualifications within the CHC waiver application.

Public Comment Target Date: April, 2016

Submission to CMS target Date: May, 2016

2. Provider Enrollment

OLTL's Bureau of Provider Management's Enrollment division accepts applications from providers electing to enroll to provide HCBS services. Prior to any enrollment the provider is required to complete the OLTL standard application form and materials. Effective July 1, 2015, the application form includes questions and information related to the HCBS final rule. Applicants that are identified as not in compliance with the final rule will be required to complete the provider self-survey and may be subject to an on-site visit by OLTL as well as submission to CMS for heightened scrutiny prior to enrollment, or may have additional steps to take to be compliant with the rule before their enrollment is considered complete. No applicants as of December, 2015 have been identified for needing heightened scrutiny.

In Pennsylvania's move to managed long term services and supports, services must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a NF, Intermediate Care Facility, Institute for Mental Disease or Hospital, unless it meets the standards for the heightened scrutiny process established through the HCBS Final Rule and is included in the PCSP.

3. Training

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OLTL staff, providers, participants, family members, and Service Coordinators will receive education and training on the updated policies and procedures that are developed as a result of OLTL’s assessment and remediation efforts. OLTL will periodically offer training to HCBS providers through face-to-face methods or by webinar, which will cover clarifications relating to the final rule as well as any new policy or procedures providers will be expected to comply with. HCBS providers who need to take additional steps to come into compliance with the final rule will receive technical assistance from OLTL in order to become compliant.

Target Date: August and September, 2016

4. Monitoring and Compliance

OLTL's overall strategy will rely heavily on its existing HCBS quality assurance processes to ensure ongoing provider compliance with the HCBS final rule. This will include provider identification of remediation strategies for each identified issue, and ongoing review of status and compliance. OLTL will also provide guidance and technical assistance to providers to assist providers with ongoing compliance. Providers that do not remain compliant with the HCBS final rule may be subject to sanctions ranging from probation to disenrollment.

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 located throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator.

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, provider requirements established in the approved waivers and any OLTL policies. OLTL will revise the QMET on-site monitoring tool to capture the new standards that will be published in July 2016. These revisions will include elements of a detailed look at every site, and review of the administered Participant Review Tool. The QMET will begin monitoring to the new standards in the beginning of 2017, which will allow providers sufficient time to complete the activities necessary to come into compliance with the new standards, policies and service definitions. Compliance with final rule requirements will be assessed and validated through a regular QMET monitoring site visit. The QMET will be conducting an onsite assessment at all sites which have been identified to be in a category that requires follow-up for compliance review. These assessments will include a walk-through of the site where HCBS services occur, as well as participant file reviews and a review of the site’s policies and procedures.

OLTL will issue a Statement of Findings (SoF) to providers listing infractions (areas of non-compliance) and immediate need for the provider to take corrective action. Based on the areas of non-compliance, OLTL will issue a Corrective Action Plan (CAP) for provider remediation. Provider remediation activities are documented in CAPs which will be requested from providers by the QMETs to correct non-compliance issues. The CAP will provide detailed information 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 develop a process on how to continue compliance with the regulations. As part of the remediating process, areas of non-compliance with the regulations are identified from the on-site review and a SoF is generated. The provider responds to the written SoF by completing a CAP. The CAP includes some of the following: action steps to address a specific finding; explanation on how the steps will remediate the finding; date when a finding will be remediated and the agency responsible person for correcting the identified problem. The provider must implement the approved CAP. 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 or the area which

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was deemed out of compliance. 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. Providers that are unable or unwilling to comply with their CAP will be dis-enrolled from providing HCBS waiver services for that setting and are required to adhere to **§ 52.61. Provider cessation of services.**

- (a) If a provider is no longer able or willing to provide services, the provider shall perform the following:
 - (1) Send written notification to each participant, the Department and other providers with which the provider works that the provider is ceasing services at least 30 days prior to the provider ceasing services.
 - (2) Notify licensing or certifying entities as required.
 - (3) Send the Department a copy of the notification sent to a participant and service providers as required under paragraph (1). If the provider uses a general notification for all participants or service providers, a single copy of the notification is acceptable.
 - (4) Cooperate with the Department, new providers of services and participants with transition planning to ensure the participant’s continuity of care.
- (b) If the provider fails to notify the Department as specified in subsection (a), the provider shall forfeit payment for each day that the notice is overdue until the notice is issued.

Providers determined to be ineligible after the CAP process will be provided appeal rights. OLTL will keep a “tracker” of HCBS providers who have been deemed out of compliance with the final rule, including how many participants they serve where they are out of compliance. OLTL will be tracking these providers and participants through the Corrective Action Plan process, and or the disenrollment process to make sure no participants, and no sites are forgotten. OLTL waiver providers are continuously monitored for compliance during a 2-year cycle per waiver requirements.

In addition, participants will be able to report any non-compliance issues through a Participant Review Tool. OLTL has developed a Participant Review 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. Service Coordinators will conduct a face-to-face visit with the participant and complete the department issued Participant Review Tool. This will ensure that participants have a method to provide feedback and report any non-compliance issues to OLTL through their service coordinator. The participant review tool was tested in April and March of 2015. OLTL is required to upgrade their license for the IT software that the participant review tool is housed. Due to a budget impasse, OLTL has not been able to purchase the license; therefore the participant review tool is anticipated to be implemented in June 2016.

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

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performance. 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 and follow-up.

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. OLTL will work with each participant, their families, and their HCBS service providers in assisting the participant to transfer out of the non-compliant site. The participant and their families will have the option of choosing between compliant HCBS providers and non-disability specific settings.

5. Public Notice for Heightened Scrutiny:

OLTL preliminarily identified 4 settings that may be subject to heightened scrutiny due to physical location and the potential to have the effect of isolating in accordance with the HCBS Final Rule. The number of settings identified may change depending on the analysis of the QMET visits. OLTL will be working with providers during the transition period to come into compliance with the HCBS final rule by implementing OLTL specific policies and procedures for better measurement of compliance with the final rule. A public notice will be published in January 2018, which will list all settings/providers that have been found eligible for continued waiver reimbursement and meets criteria for CMS heightened scrutiny process, including the number of participants currently receiving services in those settings. In the spring of 2018, OLTL will send a list of settings/providers identified for heightened scrutiny to CMS for their heightened scrutiny process, including the number of participants currently receiving services in those settings. Notice for the stakeholders will be published regarding the settings/providers CMS accepted as being home and community based and those that CMS denied as being home and community based.

CONTINUED OUTREACH AND ENGAGEMENT

This plan is not a onetime and done activity. Due to the many changes that OLTL will be implementing over the next several years, it is anticipated that the transition plan will need to be updated to reflect those changes as they occur. OLTL will change its own processes and protocols based on the rule's requirements, will at regular intervals monitor providers through a variety of mechanisms and will include stakeholder input throughout these ongoing activities. Any changes to the Transition Plan will be put out for public input and a variety of input venues will be used to ensure that participants, providers, advocates and the general public have an opportunity to express their views.

In addition, in order to provide OLTL with ongoing advice, a subcommittee of the Department of Human Services' Medical Assistance Advisory Committee (MAAC) has been established. The purpose of the Managed Long-Term Services and Supports (MLTSS) Subcommittee will be to review materials and advise the MAAC and the Department on policy development, program administration and new and innovative approaches to long-term services as the Commonwealth rolls out the new CHC delivery model. It will provide OLTL with advice on the design, implementation and ongoing operations, oversight and quality management of the CHC program. Membership of the committee includes consumers of long-term living services, providers of services, family caregivers and advocates. The MLTSS Subcommittee meets monthly to discuss the proposed policies and changes. OLTL will be using this forum to communicate any updates or changes to the Statewide Transition Plan (STP) as well as the OLTL waiver specific transition plan updates. Lastly, OLTL conducts stakeholder webinars every third Thursday of the month. These webinars have been primarily focused on the implementation of CHC, however, moving forward; OLTL believes this is a great opportunity to provide education and information on the STP as well as the OLTL waiver specific transition plans to our stakeholders.

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