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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
OLTL continues to refine and enhance the language in the OBRA waiver to better reflect current practice and policies to ensure consistent implementation. Notable changes in each Appendix in this amendment include:

Main Module
- Revises the actions OLTL plans to take to achieve compliance with the Setting requirements for the OBRA Waiver.
- Adds a transition plan for the transition of OBRA wavier participants to Community HealthChoices (CHC), Pennsylvania's Managed Long-term Services and Supports (MLTSS) model of service, which will be rolled out across the commonwealth beginning January 1, 2017.

Appendix A - Waiver Administration and Operation
- No significant changes were made to this appendix.

Appendix B – Participant Access and Eligibility
- Adjusts the number of unduplicated recipients served to reflect the rollout of CHC.

Appendix C – Participant Services
- Breaks out the components of the Home Health and Therapeutic & Counseling service definitions and creates discreet service definitions for the following: Nursing, Physical Therapy, Occupational Therapy, Speech and Language Therapy, Behavior Therapy, Counseling Services, Cognitive Rehabilitation Therapy and Nutritional Consultation. These changes were made to provide clarification on the provider qualifications for each service.
- Clarifies that certain services that are available to participants under age 21 are covered in the State Plan pursuant to the EPSDT benefit.

Appendix D – Participant-Centered Planning and Service Delivery
- No significant changes were made to this appendix.

Appendix E – Participant Direction
- No significant changes were made to this appendix.

Appendix F – Participant Rights
- No significant changes were made to this appendix.

Appendix G – Participant Safeguards
- No significant changes were made to this appendix.

Appendix H – Quality Improvement Strategy
- No significant changes were made to this appendix.

Appendix I – Financial Accountability
- No significant changes were made to this appendix.

Appendix J – Cost Neutrality Demonstration
- Modifies projections of unduplicated recipients and expenditures for the new employment services.

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

1. Request Information (1 of 3)

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

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

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: PA.0235
Waiver Number:PA.0235.R05.00
Draft ID: PA.037.05.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/16

1. Request Information (2 of 3)

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

☐ **Hospital**
Select applicable level of care
○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care
○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:
◉ **Not applicable**
○ **Applicable**
Check the applicable authority or authorities:
☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

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

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Pennsylvania's OBRA Waiver has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. The OBRA Waiver provides home and community-based services to persons 18 and over with physical developmental disabilities who require an Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) 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 OBRA Waiver. The Office of Long-Term Living, (OLTL) as part of the single SMA, is responsible for ensuring that the OBRA 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 OBRA Waiver services statewide to all participants who meet programmatic eligibility requirements and are Medicaid eligible.

OLTL has written provider agreements with service providers across the Commonwealth who meet all waiver requirements and are enrolled in Medical Assistance. These local OBRA 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.

Participants access services through a statewide Independent Enrollment Broker that assists individuals with enrollment into the waiver. The local Area Agencies on Aging (AAAs) are delegated the task of performing level of care assessments as part of the waiver eligibility process. OLTL has direct oversight of the assessment tasks of the local AAAs. The performance of the initial level of care assessments at the local level is accomplished through contracts with 52 Area Agencies on Aging (AAAs) covering all 67 counties in the Commonwealth.

OLTL has direct oversight of these contracted entities.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

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

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider

that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

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 OBRA waiver-specific transition plan, and proposed changes included in the renewal.

Timeline:

Specifically in the drafting of the OBRA renewal and transition plan, the following strategies were undertaken:
• February 9, 2016 discussed at the Long – Term Care Subcommittee of the MAAC
• February 25, 2016 discussed at the Medical Assistance Advisory Committee
• February 26, 2016 distributed via the OLTL ListServ and posted on the OLTL website
http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/2016OBRAWaiverRenewal/index.htm#
• February 26, 2016 distributed a separate email to all Service Coordination Entities with a prepared information sheet for participants
• February 27, 2016 Public Notice was published in the Pennsylvania Bulletin and distributed via email and in paper copy
• March 1, 2016 notification sent out to various stakeholders, including waiver participants, through the Policy Information Exchange, via email and paper newsletter
• March 2, 2016 discussed at the Managed Long-Term Services and Supports Subcommittee of the MAAC
• March 9 and March 23, 2016 hosted webinars for all interested stakeholders
• April 6, 2016 Comments will be shared with the Managed Long-Term Services and Supports Subcommittee of the MAAC
• April 12, 2016 Comments will be 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 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 OBRA Waiver participants.

Summary of Public Input Opportunities:

The required public notice was conducted for the proposed OBRA Waiver renewal as follows. On February 26, 2016, OLTL distributed the public notice announcing the availability of the renewal documents via the OLTL ListServ and posted it on the OLTL website at http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm#. In addition, a Public Notice was published in the Pennsylvania Bulletin on February 27, 2016, which is distributed electronically and in paper format via subscription. The official public comment period ended on March 28, 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 renewal. 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 is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Allen

First Name: Leesa

Title: Deputy Secretary

Agency: Office of Medical Assistance Programs, Department of Human Services

Address: 625 Forster Street

Address 2: 515 Health & Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17120

Phone: (717) 787-1870 **Ext:** ☐ **TTY**

Fax: (717) 787-4639

E-mail: leallen@pa.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Pennsylvania**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with 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: Virginia Brown

State Medicaid Director or Designee

Submission Date: Jun 8, 2016

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

Last Name:

Allen

First Name: Leesa

Title: Deputy Secretary

Agency: Office of Medical Assistance Programs, Department of Human Services

Address: 625 Forster Street

Address 2: 515 Health & Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17120

Phone: (717) 787-1870 **Ext:** ☐ **TTY**

Fax: (717) 787-4639

E-mail: leallen@pa.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

OBRA 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 will begin in January 2017 in southwestern PA, in January of 2018 in southeastern PA and in 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 waivers to one 1915(b)/(c) CHC waiver. That waiver will have a nursing facility (NFCE) level of care.

Because the OBRA Waiver requires an Other Related Condition (ORC) level of care, it poses a need for special handling of participant

transitions. In order to assure for the appropriateness of waiver services and the health and welfare of participants, DHS will have clinical eligibility determinations performed for all OBRA Waiver participants. These clinical eligibility determinations will begin in July 2016 in preparation for the rollout of CHC in southwestern PA and will continue to be completed in sync with the CHC rollout schedule across the state. All OBRA participants will remain in the OBRA Waiver until their zone is transitioned into CHC.

The transition process to CHC is as follows:
1. Beginning in May, the Office of Long-Term Living (OLTL) is sending notices to all OBRA waiver participants, starting in the southwest area of the state affected by the CHC transition this year, explaining the CHC transition and the need to complete a new level of care assessment. The Service Coordinator is responsible for contacting the OBRA Waiver participant within six months of the beginning of each CHC roll-out phase to educate them on CHC and coordinate the completion of a clinical eligibility determination (level of care assessment).

2. The Service Coordinator is responsible for contacting the OBRA Waiver participant within six months of the beginning of each CHC roll-out phase to educate them on CHC and coordinate the completion of a clinical eligibility determination (level of care assessment). SCs will make phone contacts, face to face visits or send letters as appropriate to meet the needs of the OBRA waiver participant. Service coordinators are required to answer any questions participants and family members have about CHC, the transition and the level of care reassessment process. OLTL will provide Service coordinators a document with key information about Community HealthChoices to use in responding to questions from participants.

In addition, service coordinators are being asked to assist participants in obtaining completed physician certification forms if requested by the participant. Area Agencies on Aging (AAAs) will be responsible for completing the level of care reassessments for all OBRA participants. OLTL is working with the AAAs to inform them of the OBRA waiver participants in the county for whom they must complete level of care reassessments. AAAs will make contact with the participant and send a physician certification form to the participant's physician, unless the participant chooses to assume responsibility for getting the physician certification form completed.

3. The results of the clinical eligibility determination will be forwarded to OLTL If the participant was found to meet the NFCE level of care, the participant will receive a pre-transition letter from OLTL, followed by an enrollment information packet. The enrollment information packet will include important action dates for the participant.

4. The Independent Enrollment Entity (IEE) will be available to participants for telephonic or face-to-face choice counseling to choose the best plan for their needs. The Department 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, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a plan in which their nursing facility is a Network Provider.
- Second, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP.
- Third, 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 HCBS provider 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.

5. Once a recipient has chosen or is assigned to a managed care plan, the Department 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 OBRA waiver to the Community HealthChoices 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 OBRA 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 are outlined in the Program Requirements and Agreement signed between the CHC-MCOs and the Department.

The OBRA 1915(c) waiver will not be operated concurrently with the Community HealthChoices 1915(b) waiver. Those waiver participants who do not meet nursing facility clinical eligibility, or the age requirements of CHC, will either remain in the OBRA Waiver or be transitioned to a more appropriate DHS waiver or state program, depending on their assessed needs. It is the Department of Human Services' intent to reduce the number of individuals served through the OBRA waiver. The Department will maintain sufficient "slots" so that individuals who do not meet the CHC Waiver eligibility requirements either do not lose services (current enrollees) or access to services (future enrollees). These "slots" have been projected based upon the anticipated number of individuals transitioning to CHC and the historical enrollment of individuals between 18 and 21.

In addition, the Department anticipates transferring all 18 to 21 year olds who are currently enrolled in other OLTL waivers into the OBRA wavier. If these participants are eligible for CHC when they reach 21, or become eligible at any point in the future, they will be transitioned to CHC. If not, they will remain in the OBRA wavier.

As described in Appendix F, Participant Rights, waiver participants have the right to request a fair hearing if changes in the renewal result in a denial, reduction, termination, or suspension of their services. Participants will be informed of their opportunity to request a fair hearing when Service Coordinators issue a Notice of Service Determination and the Right to Appeal form to each participant whose services are affected by changes in this waiver renewal.

There are no changes in this renewal that negatively impact waiver participants.

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 OBRA Waiver Transition Plan
January, 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
   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 OBRA Waiver: The OBRA Waiver serves individuals ages 18-59 who meet the level of care for Intermediate Care Facility/Other Related Conditions (ICF/ORC), and are financially eligible for MA waiver services.

The following services are available through the OBRA Waiver:
- Adult Daily Living
- Assistive Technology
- Community Integration
- Community Transition Services
- Financial Management Services
- Home Health
- Home Modifications
- Non-Medical Transportation
- Personal Assistance Services

- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation Services
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day Habilitation Services
- Supported Employment
- Therapeutic and Counseling Services
- Vehicle Modifications

*OLTL is adding the following Service Definitions to this OBRA renewal: Benefits Counseling, Career Assessment, Employment Skills Development, Job Coaching, and Job Finding services. The new Employment Service Definitions have not been assessed as they are new service definitions for the OBRA Waiver.

Timeline:
The HCBS transition plan for the OBRA 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 and distributed via email and in paper copy
- 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
- 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.

The required public notice was posted and the second comment period was achieved according to the following schedule:

- December 9, 2014 discussed at the Long-Term Care Subcommittee of the MAAC
- December 19, 2014 distributed via the OLTL ListServ and posted on the OLTL website http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm
- December 20, 2014 Public Notice was published in the Pennsylvania Bulletin and distributed via email and paper copy
- January 6 and January 8, 2015 hosted webinars for all interested stakeholders
- January 8, 2015 notification sent out to various stakeholders, including waiver participants, through the Disability Rights Network via email and paper newsletter
- January 22, 2015 discussed at the Medical Assistance Advisory Committee

*The OBRA waiver transition plan was submitted to CMS on March 31, 2015. What follows is an updated transition plan that includes updated results of OLTL's assessment phase, additional stakeholder activity, and more detailed remediation steps.

The OBRA 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 Independence waiver transition plan was distribute via the OLTL ListServ and posted on the OLTL website
- January 9, 2016 Public Notice was published in the Pennsylvania Bulletin via email and paper copy
- 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

Finally, the OBRA waiver transition plan was subject to an additional round of public input as part of the public input process for this waiver renewal as described in Main Module 6-I above.

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 OBRA 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.

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 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.

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

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 OBRA waiver services are provided in the private homes of individuals and it is, therefore, presumed that the settings are 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 http://questionpro.com/t/ALHsBZSEE4 Providers were asked to complete a survey for each site location at which they provider 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. Furthermore, OLTL identified the residential and day settings that did not complete surveys and reached out to each of those settings. For the residential and day providers that still failed to submit a survey, OLTL's QMET team is following up with a letter and site visit to complete the survey and provide technical assistance and education on the HCBS Final Rule.

OLTL's QMET teams began on-site visits to all provider owned and operated and day settings in October and will be complete in December, 2015.

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

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 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.

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. Overnight Personal Assistance Services to provide intermittent

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 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.

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 at attorney, or reside in the home.

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.

Vehicle Modifications: Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant, ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community.

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.

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

Supported Employment: Supported Employment Services are paid employment services for persons for whom competitive employment at or above the minimum wage is unlikely, and who because of their disability need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training of the individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.

Respite provided in a Nursing Facility: 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.
*This has been deemed allowable by CMS

STILL UNDER ASSESSMENT
ASSESSMENT ACTIVITES ARE STILL OCCURING FOR THE FOLLOWING SERVICE 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.

a. DomCare Settings
b. Prevocational Services
c. Residential Habilitation Service settings(Provider Owned and Controlled)
d. Structured Day Habilitation Service settings

Type of Setting: DomCare Setting
Issue: Lockable bedroom doors
Number of Settings: 1 service location
Service Setting Description: A premises certified by an Area Agency on Aging (AAA) for the purpose of providing a supervised living arrangement in a homelike setting.

Type of Setting: Prevocational Services
Issue: Still under assessment
Number of Settings: 14 Service locations
Service Setting Description: Prevocational services prepare a participant for paid competitive employment or other employment and are provided under the auspices of a licensed vocational facility. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying goals directed at assisting the participant towards greater independence. Services include teaching such concepts as compliance, attendance, task completion, problem solving, safety, and habilitative skills for integrated employment. Waiver funding is not available for the provision of vocational services (e.g. sheltered work performed in a facility)

Type of Setting: Residential Habilitation
Issue: Changes are needed to ensure that all provider-owned residential settings:
Provide a lease or legally enforceable agreement that complies with PA landlord-tenant laws.
Further issues may be identified through the QMET site visits. Site visits are scheduled to conclude in December, 2015. The QMET findings will influence policy development.
Number of Settings: 29 service locations

Service Setting Description: Residential Habilitation can be provided in Licensed and unlicensed settings. Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 PA Code Chapter 2600). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents. Residential Habilitation services are provided for up to 24 hours a day. Residential Habilitation services are designed to assist an individual in acquiring the basic skills necessary to maximize their independence in activities of daily living and to fully participate in community life. Residential Habilitation services are individually tailored to meet the needs of the individual as outlined in the individual's service plan. Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping). Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their individual service plans (ISPs). This includes transportation to and from day habilitation and employment services.

Residential Habilitation services may be provided to participants in Personal Care Homes and Assisted Living Residences, which must demonstrate a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining areas, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Personal Care Homes are licensed under Title 55 PA Code 2600 and Assisted Living Residences are licensed under Title 55 PA Code 2800. Licensed settings serving individuals in the OBRA waiver may not exceed a licensed capacity of more than 8 unrelated individuals. Both are designed to provide safe, comfortable and supportive residential settings for adults. Residents who live in Personal Care Homes and Assisted Living Residences receive the encouragement and assistance they need to develop and maintain maximum independence and self-determination. Bedrooms in both settings should be individualized and show signs of personalization such as photos, bedding, art or other decorations selected by the resident. The kitchen may not contain signs of institutionalization like locks on cabinets. Furniture cannot be uniform or institutional in nature. The bathrooms are personalized with towels and toiletries that reflect the participant's personal preferences. The setting is decorated with personal photos, arts, and other decorations that reflect the participant's tastes living in the home.

Type of Setting: Structured Day Habilitation Services
Issue: Still under assessment. Issues may be identified through the QMET site visits. Site visits are scheduled to conclude in December, 2015. The QMET findings will influence policy development.
Number of Settings: 14 Service Locations
These services are directed toward the development and maintenance of community living skills. Services will normally be furnished two or more hours per day on a regularly scheduled basis, for one or more days per week. Structured day program services include supervision and specific training to allow the consumer to attain his or her maximum potential. Services may include social skills training, sensory/motor development, and reduction/elimination of maladaptive behavior. Services directed at preparing the consumer for community reintegration (teaching concepts such as compliance, attending, task completion, problem solving, safety, money management, etc.) are also included. Physical, occupational, speech and cognitive rehabilitation therapies will also be provided in addition to the structured day program if needed as documented in the approved service plan.

REMEDIATION 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 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 over three years, beginning in January 2017. The first phase in period will begin on January 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 mentioned 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: March, 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: March, 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. At this time OLTL is proposing to revise the Prevocational and Supported Employment service definitions to the following: Career Assessment, Employment Skills Development, Job Coaching, and Job Finding
Public Comment Target Date: Will be coordinated with the dates and timeframes with the phase in of CHC
Submission to CMS target Date: Will be coordinated with the dates and timeframes with the phase in of CHC

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, OLTL will be including language in agreements with Managed Care Organizations that reflect the final rule, and will make it clear that the managed care organizations are responsible for contracting with providers that are compliant with the final rule.

3. Training
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 in the future. 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 Dates for Training: 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 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 sites policies and procedures. QMET will responsible for monitoring providers in the regions of the State that have not yet implemented CHC. Compliance will be assessed and validated through a regular QMET monitoring site visit.

With each phase in period of CHC, the MCOs will be responsible for ensuring providers in their networks are compliant with OLTL policies related to the HCBS Final Rule.

Until CHC implementation in each region is complete, 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 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 at 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 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 has not identified any 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. If the number of settings changes, 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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A.3 Additional Information

In addition to these delegated activities, the F/EA also serves to:
• Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
• Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees;
• Assist participants in verifying support workers citizenship or alien status;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
• Maintain funds for individual service budgets separately and with full accounting;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through an appropriate agency;
• Process all judgments, garnishments, tax levies or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually; and
• Establish an accessible customer service system for the participant and the Service Coordinator.

Performance of annual redeterminations of level of care is currently conducted by service coordination entities as described in Appendix C. As noted above, effective September 1, 2016, OLTL will be entering into a contract with an independent Assessment Entity to conduct the initial and annual Clinical Eligibility Determinations/Redeterminations.

Administration and oversight of these contracts falls within the purview of OLTL and the Department of Human Services. The assessment methods used to monitor performance of contracted entities are described below in A-1-6 below.

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   ( ) **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Office of Long-Term Living
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
The OBRA waiver is administered by the Pennsylvania Department of Human Services (DHS), Office of Long-Term Living (OLTL), an office within the Single State Medicaid Agency. OLTL exercises administrative discretion in the administration and is responsible for oversight of the waiver, as well as all policies, procedures and regulations. OLTL is responsible for the development of waiver related policies, rules, and regulations, which are issued electronically by OLTL through Bulletins and other communications.

The Deputy Secretary of the Office of Long-Term Living reports directly to the Secretary of the Department of Human Services (DHS), the head of the Single State Medicaid agency. The Secretary of DHS and the Deputy Secretary of the Office of Long-Term Living meet weekly to discuss operations of the waiver and other long term living programs, and gain consent on Waiver policies, rules and guidelines. In addition, the OLTL Policy staff meet with the State Medicaid Director on a monthly basis.

All waiver-related policies, renewals and amendments undergo an extensive review process, which includes review by the State Medicaid Director. Policy guidance, which is authorized through the 55 Pa. Code, Chapter 52 regulations, is issued after it is reviewed by OLTL Bureau Directors, the Long-Term Services and Supports Subcommittee of the Medical Assistance Advisory Committee, DHS leadership offices, including Legal, Policy and Budget (if applicable) and the State Medicaid Director, and issued after signature by OLTL's Deputy Secretary. All waiver-related documents go through the same process but are additionally issued for public comment through the Pa. Bulletin, OLTL listservs and a disability advocacy group. They are then further reviewed by the DHS Secretary's Office, the Governor's Offices of Budget, General Counsel and Policy and, finally, by the Legislative Reference Bureau.

The following details waiver-related organizational responsibilities within OLTL:
• Bureau of Participant Operations (BPO) – effectively operationalizes home and community based waiver programs through oversight of participant enrollment functions; review and approval of individual service plans, provision of programmatic guidance to service coordinators and providers. Also manages the participant helpline and provides assistance to service coordinators on protective services cases.

• Bureau of Policy and Regulatory Management – evaluates existing policies and develops new policies to provide uniform guidelines to other OLTL bureaus and to the HCBS provider community. Develops and submits waiver amendment to CMS; develops communications for providers and the general public to convey OLTL's policies and strategic vision; develops regulations, statements of policy and rate notices as needed; monitors and reviews state and federal policies for impact on HCBS programs.

• Bureau of Bureau of Quality and Provider Management – conducts quality management and improvement monitoring of long-Term Living programs and services to ensure compliance with federal and state regulations and the delivery of quality programs to assure the health and welfare of consumers; ensures that program and service delivery systems achieve desired outcomes. It also oversees provider management functions for OLTL including provider certification and enrollment; updates

provider files; oversees MA provider billing; prepares financial reports as appropriate, including reports required by the Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies.

• Bureau of Finance – is responsible for financial operational management of the waivers and ongoing monitoring of expenditures and related information; oversees and develops HCBS service rates; provides budget analysis to help inform policy decisions.

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

Appendix A: Waiver Administration and Operation

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

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

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL currently contracts with fifty-two (52) local Area Agencies on Aging to perform the initial level of care determination as specified in Appendix B-6. Thirty-three of these entities are Local/Regional non-state public agencies, while nineteen are Local/Regional non-governmental non-state entities.

OLTL also contracts with one non-governmental non-state entity to facilitate eligibility determinations (waiver related enrollment activities), excluding level of care determinations, for multiple home and community-based waivers managed by OLTL, including the OBRA waiver. Specifically, the Independent Enrollment Entity (IEE) is responsible for the following activities:
• Complete the initial in-home visit and needs assessment;
• Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider;
• Provide applicants with choice of receiving ICF-ORC institutional services, waiver services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form;
• Provide applicants with a list of qualified Service Coordination agencies and document the individual's choice of Service Coordinator on the OLTL Service Provider Choice Form;
• Assist the applicant to obtain a completed physician certification form from the individual's physician;
• Refer the applicant to the independent Assessment Entity for the clinical eligibility determination;
• Assist the participant to complete the financial eligibility determination paperwork;
• Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms; and
• Maintain a waiting list for services as necessary.

OLTL also contracts with one Fiscal Employer/Agent (F/EA) to perform certain functions for the successful operation of participant direction.
These administrative functions delegated to the FMS by OLTL include:
• Execute Medicaid provider agreements with qualified vendors and support workers;
• Assist in implementing the state's quality management strategy related to FMS; and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis and as requested by the participant, Service Coordinator and OLTL

In addition to these delegated activities, the F/EA also serves to:
• Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries;

and workers compensation;
• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
• Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees;
• Assist participants in verifying support workers citizenship or alien status;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
• Maintain funds for individual service budgets separately and with full accounting;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through an appropriate agency;
• Process all judgments, garnishments, tax levies or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually; and
• Establish an accessible customer service system for the participant and the Service Coordinator.

Performance of annual redeterminations of level of care is currently conducted by service coordination entities as described in Appendix C.

Administration and oversight of these contracts falls within the purview of OLTL and the Department of Human Services. The assessment methods used to monitor performance of contracted entities are described below in A-1-6 below.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates a component of the initial level of care assessment to determine clinical eligibility for waiver services to fifty-two (52) local Area Agencies on Aging (AAAs). Thirty-three (33) of the AAAs are local county-based organizations - non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and in accordance with all applicable policies and procedures.

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

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

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

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL delegates a component of the initial level of care

assessment to determine clinical eligibility for waiver services to fifty-two (52) local Area Agencies on Aging (AAAs). Nineteen (19) of the AAAs are non-governmental non-state public agencies. The AAA is responsible for meeting the requirements as outlined in the Title XIX Agreement and all applicable policies and procedures.

OLTL has state level oversight authority over the enrollment function. Through a competitive procurement process, OLTL has a contract with one statewide Independent Enrollment Entity (IEE). The IEE facilitates eligibility determinations for multiple home and community-based waivers managed by OLTL. The IEE does not provide any ongoing direct services to the participant. The IEE's responsibilities are outlined above in Appendix A-3.

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

Annual Re-evaluations – As noted above, the annual reevaluation for level of care is currently conducted by the local Service Coordination entities as described in Appendix C.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
OLTL remains the ultimate authority for Waiver policies, rules, and regulations; and retains the ultimate authority on all administrative decisions. OLTL retains the responsibility for supervision and assessment of the performance of AAAs and other contracted entities. OLTL provides information and technical assistance to AAAs and Service Coordination entities through the Long-Term Living Training Institute, targeted technical assistance, and upon request.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
OLTL has undertaken a number of efforts to strengthen the methods for overseeing entities performing administrative elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring.

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☐	☐
Prior authorization of waiver services	☑	☐	☐
Utilization management	☑	☑	☐
Qualified provider enrollment	☑	☐	☐
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
SAMS Report

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

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

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

Performance Measure:
AA-3: Number and percent of contractual obligations met by the Independent Enrollment Broker Numerator: Total number of contractual obligations that were met by the IEB Denominator: Total number of contractual obligations of the IEB

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

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

Data Aggregation and Analysis:

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

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

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report using waiver enrollment and census data

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider will be reviewed every two years, at minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application.
The Bureau of Quality & Provider Management (BQPM) reviews AAAs regarding the initial LOC, reevaluations of LOC, F/EA and enrollment functions. The BQPM uses standard monitoring tools which outline the provider requirements as listed in the waiver and the Fiscal/Employer Agent (F/EA) contract, including LOC determination, F/EA, and enrollment functions. The BQPM verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum.

Q16. The State will follow the sampling methods and timelines as outlined in the waiver specific transition plan.

For information regarding the Bureau of Quality and Provider Management (BQPM), and the Quality Improvement Strategy, please refer to Appendix H for detailed information.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written notification of outstanding issues with a request for a Corrective Action Plan (CAP). The CAP is due to the QMET within 15 working days. BQPM staff reviews and accepts/rejects the CAP within 30 working days. Monitoring by the QMET occurs to ensure the CAP was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue, technical assistance is provided by BQPM.

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

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[ ] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[ ]	Disabled (Physical)			
	[ ]	Disabled (Other)			
[ ] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[ ]	Medically Fragile			[ ]
	[ ]	Technology Dependent			[ ]
[x] Intellectual Disability or Developmental Disability, or Both					
	[ ]	Autism			[ ]
	[x]	Developmental Disability	18	59	[ ]
	[ ]	Intellectual Disability			[ ]
[ ] Mental Illness					
	[ ]	Mental Illness			
	[ ]	Serious Emotional Disturbance			

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

Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA Waiver until services are no longer needed. New applicants age 60 and older will be referred to the Aging waiver.

Waiver services are limited to individuals with developmental disabilities, and who meet all of the following conditions:
1. Individuals who have a developmental disability (but do not have a primary diagnosis of either mental retardation or a major mental illness),
2. have been assessed to require services at the level of an ICF/ORC;
3. The disability manifested prior to the age of 22;
4. The disability is likely to continue indefinitely;
5. The disability results in three or more substantial functional limitations in major life activity: self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living.

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- ○ **Other**

  Specify:

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

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

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

- ○ **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

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

    Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1379
Year 2	1097
Year 3	748
Year 4	400
Year 5	400

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1338
Year 2	1064
Year 3	725
Year 4	387
Year 5	387

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Nursing HomeTransition/ Money Follows the Person	

Appendix B: Participant Access and Eligibility

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

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

Nursing HomeTransition/ Money Follows the Person

Purpose *(describe):*

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the OBRA Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the OBRA Waiver. Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.

Describe how the amount of reserved capacity was determined:

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

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

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

Waiver Year	Capacity Reserved
Year 4	2
Year 5	1

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

All individuals that are eligible for the waiver will be served. In the event of a waiting list for waiver services, the following entry criteria will be used:

1. Individuals who are currently receiving Medical Assistance in an institutional placement and need waiver services to transition into the community.

2. Individuals who are at risk of an institutional placement, which is defined as individuals who currently reside in the community and are at imminent risk of facility placement within 24-72 hours or less.

3. Individuals who are in the community but can wait more than 72 hours for home and community-based services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

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

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

Select one:

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

Specify percentage: [ ]

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
  Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

  - ◉ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the State plan**

  Select one:

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

    (*select one*):

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

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the State Plan**

    Specify:
- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:
- ( ) **Other**

  Specify:

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

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

  Specify:

  Specify the amount of the allowance (*select one*):

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

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ◉ **Other**

Specify:

The 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.

Service Coordinators, employed by MA enrolled Service Coordination Entities, conduct the annual reevaluations for participants that are already enrolled in the waiver. Service Coordinators also conduct reevaluations more frequently, if needed.

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

AAA Assessors
One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences OR

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

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

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

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

The complete qualifications of the AAA Case Managers are located at the Department of Aging website at http://www.aging.state.pa.us; click on Aging Program Directives link then Home and Community Based Services Procedural Manual.

Physicians
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 (MA-51). OLTL does not contract directly with physicians to perform participant evaluations. When a participant presents to the independent enrollment entity (IEE), the IEE sends a request to the applicant's primary care physician to fill out and return a physician's script indicating that the waiver applicant requires the level of care provided in a Nursing Facility.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care

instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Per 55 PA Code, Chapter 6210.62, an individual requires services at the level of an Intermediate Care Facility for Persons with an Other Related Condition (ICF/ORC) when they meet the following criteria:
1. Requires active treatment;
2. Has a diagnosis of an other related condition; and
3. Has been recommended for an ICF/ORC level of care based on a medical evaluation.

An Other Related Condition is defined as a severe, chronic disability (other than mental illness or an intellectual disability) that: (1) manifested before to age 22; (2) is likely to continue indefinitely; (3) and results in the impairment of either general intellectual functioning or adaptive behavior; and (4) results in substantial functional limitations in at least three of the following areas of major life activities – self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living. "Other related conditions" may include, but are not limited to, cerebral palsy; spina bifida; epilepsy; severe physical disabilities, and autism.

Active treatment means a continuous program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

When an applicant is applying for services the Independent Enrollment Broker (IEB) submits a physician certification form and cover letter with an explanation of the application for home and community-based services to the applicant's physician. The physician will indicate the applicant's level of care and return it to the enrollment entity. The physician certification form includes:
- Physician's recommendation of level of care required – either nursing facility clinically eligible, ICF/ORC eligible, or none of the above with an explanation
- 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

Currently, the local Area Agency on Aging (AAA) uses the Level of Care Determination (LCD), to determine the individual's disability, age of on-set and functional limitations.

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

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

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

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

Initial Level of Care Determination:

The Office of Long-Term Living (OLTL) uses the following process to determine an individual's initial level of care:
• The applicant first applies for OBRA Waiver services through the statewide Independent Enrollment Entity (IEE). The role of the independent enrollment broker is to facilitate and support the participant through the enrollment process including the level of care evaluation. The enrollment broker follows the status of the level of care determination process and assists with any required communication between the participant, the participant's physician, and the AAA.
• The IEE makes a referral to the local Area Agency on Aging (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 AAA visits the applicant within 15 days of receiving the referral from the IEE, and uses the standardized level of care determination (LCD) 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 applicant's physician completes the physician certification form indicating the applicant's diagnosis and the physician's clinical eligibility recommendation. Once complete, the IEE forwards the physician's certification form to the AAA.
• The IEE 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 AAA is responsible for making the final clinical eligibility decision subject to OLTL oversight. In instances where the applicant's physician and the assessor differ on the final clinical eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination.

Annual Redetermination:

The participant's Service Coordination agency is responsible for completion of the annual redetermination of level of care.

• The Service Coordinator completes the annual redetermination by visiting the participant and completing the standardized needs assessment.
• The standardized needs assessment mirrors the information collected in the LCD, including information on medical changes, recent hospitalizations, changes in functional status (ADLs and IADLs), and the continued need for ICF/ORC level of care.
• The information collected in the standardized needs assessment is compared to the information collected in the individual's previous needs assessment.
• The Service Coordination Entity is responsible for making the final level of care redetermination eligibility decision.

As stated above, in instances where the applicant's physician and the assessor differ on the final clinical eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination.

OLTL ensures that the annual redetermination process is completed on time and consistent with OLTL policies through the following methods:
1. A retrospective review of valid statistical sample of service plans as described in the Quality Improvement section of Appendix D. When issues are identified, OLTL follows up with the identified Service Coordination Entity and provides targeted technical assistance.
2. On-site monitoring of Service Coordination Entities. The QMET reviews participant records to ensure the annual reevaluation was completed within 365 days from the initial level of care determination and ensure accuracy.

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

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

  Have a Bachelor's Degree in social work, social science, or related field of human service, such as psychology, and one year of case management experience, or at least six months of professional experience and at least six months as a Home and Community Based Services waiver/program participant; or

  Have an Associate's Degree in social work, social science, or related field of human service, such as psychology, and two years of case management experience, or at least one year of professional experience and at least on year as a Home and Community Based Services waiver/program participant; or

  Have successfully completed 12 credit hours of human services course work from an accredited college or university, and at least four years of professional experience, or at least two years of professional experience and at least two years as a Home and Community Based Services waiver/program participant.

  Must have required training, including at a minimum: Office of Long-Term Living's (OLTL) Service Coordination training. Each service coordinator will be required to have 40 hours of training during the first year of employment and 20 hours annually.

  Service Coordinator Supervisor must meet the same qualifications as the Service Coordinator including two years' experience as a Service Coordinator.

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):*

The Service Coordinator will ensure that a meeting with the participant in the participant's home takes place, to reassess the participant's need for waiver services by completing the standardized needs assessment form. Each Service Coordinator will be required to maintain its own tickler system to complete timely redeterminations and maintain consistency in service. The Service Coordinators are required to collect the information necessary for redeterminations every 365 days or more frequently, if needed, when there are changes in a participant's functioning and/or needs.

After the reevaluation is completed, the Service Coordinator enters the information in a service note in HCSIS. The redetermination information is also maintained in the participant's file at the Service Coordination Entity and is subject for review during OLTL biennial monitoring visits and the 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 is electronically maintained in SAMS.

In addition, copies of initial determinations and annual redeterminations are maintained in participant's file located at the Service Coordination Entity.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
LOC-1: Number and percent of waiver applicants who have an initial level of care determination that adhered to timeliness prior to receipt of waiver services. Numerator (N) = Total number of waiver applicants with an initial level of care determination that adhered to timeliness prior to receipt of waiver services Denominator (D) = Total number of all waiver applicants

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

PARTICIPANT FREEDOM OF CHOICE

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

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for OBRA Waiver services and the participant is determined to likely need the Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) level of care, the individual will be:

• Informed by the independent enrollment entity of any feasible service delivery alternatives available under the waiver; and,

• Given the choice of receiving institutional (ICF/ORC) services, waiver services, or no services

Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the IEE and ongoing by their Service Coordinator, of their right to choose between receiving community services in the waiver, institutional (ICF/ORC) 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 on-going as part of the person-centered planning process. 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 independent enrollment entity is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination Entities, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form. In addition, the enrollment entity is responsible for educating participants of their right to choose from any qualified provider, the opportunity to self-direct some or all of their direct services, and the ability to change providers at any time. The enrollment entity will give each participant information about the Services and Supports Directory, a web-based listing of all enrolled 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 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.

The Service Coordination Entity is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial Individual Service Plan, annually thereafter, and at any time during the year when a participant requests a change of providers. The Service Coordination Entity is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form. 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 choice forms in the participant's record located at the Service Coordination Entity.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Service Coordination Entities and Direct Service Providers will make waiver documents available in different languages upon request, at no charge. Language assistance will be provided by the provider without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing.

All providers are required to have and implement policies and procedures for participants with limited English proficiency to ensure meaningful access to language services as required by 55 Pa. Code Chapter 52. In addition, OLTL's contract with the Independent Enrollment Entity (IEE) requires the IEE to provide enrollment documents as well as language assistance available upon request, at no charge. Sign language services must also be made available, at no charge, to individuals who are deaf or hard of hearing.

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Daily Living**		
Statutory Service	**Personal Assistance Services**		
Statutory Service	**Residential Habilitation Services**		
Statutory Service	**Respite**		
Statutory Service	**Service Coordination**		
Statutory Service	**Structured Day Habilitation Services**		
Extended State Plan Service	**Behavior Therapy Services**		
Extended State Plan Service	**Nursing Services**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy Services**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Extended State Plan Service	**Speech and Language Therapy Services**		
Other Service	**Assistive Technology**		
Other Service	**Cognitive Rehabilitation Therapy Services**		
Other Service	**Community Integration**		
Other Service	**Community Transition Services**		
Other Service	**Counseling Services**		
Other Service	**Home Adaptations**		
Other Service	**Non-Medical Transportation**		
Other Service	**Nutritional Consultation**		
Other Service	**Personal Emergency Response System**		
Other Service	**Prevocational Services**		
Other Service	**Supported Employment**		
Other Service	**Vehicle Modifications**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Daily Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Daily Living

Provider Category:
Agency
Provider Type:
Older Adult Daily Living Center
Provider Qualifications
License *(specify)*:
Meet licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Have a minimum of 1 year of experience providing care to an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience;

• Have a high school diploma or GED;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code, Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Have disability-specific training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Aging
DHS, Office of Long-Term Living, Bureau of Quality and Provider Management

Frequency of Verification:
Department of Aging - Annually
Bureau of Quality and Provider Management - At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Daily Living

Provider Category:
Agency

Provider Type:
Adult Day Care Center

Provider Qualifications

License *(specify)*:
Meet licensing regulations under Title 55 PA Code, Chapter 2380, Subchapter A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Have a minimum of 1 year of experience providing care to an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience;
• Have a high school diploma or GED;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code, Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Have disability-specific training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS, Office of Administration, Bureau of Human Services Licensing
OLTL
Frequency of Verification:
DHS - Annually
OLTL - At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal Assistance Services primarily provide hands-on assistance to participants that are necessary, as specified in the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

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

Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include:
• Care to assist with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the participant to perform a task, and providing supervision to assist a participant who cannot be safely left alone.
• Health maintenance activities provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements.
• Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support

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

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living:
• Activities that are incidental to the delivery of Personal Assistance to assure the health, welfare and safety of the participant such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.
• Services to accompany the participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.

This service is not available for individuals between the ages of 18 and 21.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Assistance Services may only be funded through the waiver when the services are not covered by the State Plan, EPSDT, or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan, EPSDT, or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

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

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

Personal Assistance Services cannot be provided simultaneously with Home Health Care Aide Services, Residential Habilitation, or Respite. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:
Agency
Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

Agency:

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, and policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Commercial General Liability Insurance
• Have Professional Liability Errors and Omissions Insurance
• Have Workers' Compensation Insurance in accordance with State statute and in accordance with Department policies
• Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs; and
• Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.
• Individuals working for agencies must meet the following standards: Be 18 years of age or older;
• Possess basic math, reading, and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/ Department of Health

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:

Individual

Provider Type:

Individual Support Service Worker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Support Service workers must:

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department

policies;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Be 18 years of age or older;
• Possess basic math, reading, and writing skills;
• Possess a valid Social Security number;
• Submit to a criminal records check;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Have the required skills to perform Personal Assistance Services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan; and
• Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Employer Agent/OLTL

Frequency of Verification:
At least every two years and more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):
Residential Habilitation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 PA Code Chapter 2600) or Assisted Living Residences (reference 55 PA Code Chapter 2800). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents.

Residential Habilitation services are provided for up to 24 hours a day. This service is authorized as a day unit. A day is defined as a period of a minimum of 12 hours of service rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 am and ending at 11:59 pm. Residential Habilitation services are designed to assist an individual in acquiring the basic skills necessary to maximize their independence in activities of daily living and to fully participate in community life. Residential Habilitation services are individually tailored to meet the needs of the individual as outlined in the individual's service plan.

Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their individual support plans (ISPs). This includes transportation to and from day habilitation and employment services. Transportation included in the rate for Residential Habilitation Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By the nature of their behaviors, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced Staffing is treated as an add-on to the Residential Habilitation service and is only available when participants require additional behavioral supports.

Residential Enhanced Staffing may be provided at the following levels:
• Level 1: staff-to-individual ratio of 1:1.
• Level 2: staff-to-individual ratio of 2:1 or greater.

Effective July 1, 2014 licensed settings serving individuals enrolled in the OBRA Waiver may not exceed a licensed capacity of more than 8 unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by OLTL's Office of Quality Management, Metrics and Analytics through ongoing monitoring. Additionally, Service Coordinators will monitor the community character of the residence during regularly scheduled contact with residents. Results of this monitoring will be reported to OLTL. Service Coordinators assist participants in transitioning to homes of their own.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment is not made for room and board.
Residential Habilitation services do not include the provision of a structured day habilitation, adult daily living, job coaching, employment skills development, and therapies provided on a one to one basis.
Community Integration, Home Health Care Aide services, Non-Medical Transportation, Personal Assistance Services, and Respite cannot be provided at the same time as Residential Habilitation.
Long-term or Continuous Nursing cannot be on the same service plan as Residential Habilitation.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

- [ ] **Legally Responsible Person**

☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation Services

Provider Category:
Agency
Provider Type:
Licensed Residential Habilitation Provider
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Public Welfare, per 55 PA Code 2600, Personal Care Homes or 55 PA Code 2800, Assisted Living Residence
Certificate *(specify):*
By July 1, 2014 those providing residential habilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider Agreement;
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania;
• Have Commercial General Liability Insurance
• Have Professional Liability Errors and Omissions Insurance
• Have Workers Compensation Insurance in accordance with state statute and in accordance with Departmental policies
• Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs.
Individuals employed to provide Residential Habilitation services must:
Be at least 18 years of age;
• Have a high school diploma or GED;
• Have a minimum of six months of paid or volunteer experience working with people with disabilities.
• Comply with Department standards including regulations, policies and procedures related to provider qualifications;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Complete Initial Residential Habilitation Service Training within 6 months of being hired, which consists of a minimum of 12 hours of brain injury specific training.
• Complete a minimum of 12 hours of Ongoing Residential Habilitation Training annually which directly relates to job responsibilities.
• Staff who are employed to provide Enhanced Residential Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually.
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Agree to carry out the Residential Habilitation outcomes included in the participant's service plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHS/OLTL
Frequency of Verification:
DHS – Annually
OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation Services

Provider Category:
Agency
Provider Type:
Unlicensed Residential Habilitation Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
By July 1, 2014 those providing residential rehabilitation services must achieve CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program(adult) accreditation
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania;
• Have Commercial General Liability Insurance
• Have Professional Liability Errors and Omissions Insurance
• Have Workers Compensation Insurance in accordance with State statute and in accordance with Department policies;
• Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs.

Individuals employed to provide Residential Habilitation services must:
• Be at least 18 years of age
• Have a high school diploma or GED
• Have a minimum of six months of paid or volunteer experience working with people with disabilities.
• Comply with Department standards including regulations, policies and procedures related to provider qualifications;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• One (1) staff must be awake and available on call at all times.
• Complete Initial Residential Habilitation Service Training within 6 months of being hired, which consists of a minimum of 12 hours of brain injury specific training.
• Complete a minimum of 12 hours of Ongoing Residential Habilitation Training annually which directly relates to job responsibilities.
• Staff who are employed to provide Enhanced Residential Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually.
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Agree to carry out the Residential Habilitation outcomes included in the participant's service plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL
Frequency of Verification:
OLTL – At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):
Respite

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family member and are provided in quarter hour units. Respite services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

Respite is not provided in residential settings.

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

In-home Respite Services cannot be provided simultaneously with Home Health Aide Services, or Personal Assistance Services.

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

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

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

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

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

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.
Certificate *(specify):*
Certification as required by
42CFR Part 484
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Be supervised by a registered nurse;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
• Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State
• licensure program that meets the requirements of Sec. 484.36 (b) or (e).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Agency:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
• Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for agencies must meet the following standards:
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Individual Respite Worker
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent/OLTL

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Service Coordination identifies, coordinates and assists participants to gain access to needed waiver services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to participants and facilitating access, locating, coordinating and monitoring needed services and supports for waiver participants.

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

In the performance of providing information to participants, the Service Coordinator will:
• Inform participants about the waiver, required needs assessments, the participant-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities.
• Inform participants on fair hearing rights and assist with fair hearing requests when needed and upon request.

In the performance of facilitating access to needed services and supports, the Service Coordinator will:
• Collect additional necessary information, including, at a minimum, participant preferences, strengths and goals to inform the development of the participant-centered service plan.
• Conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements.
• Assist the participant and his/her service planning team in identifying and choosing willing and qualified providers.
• Coordinate efforts and prompt the participant to ensure the completion of activities necessary to maintain waiver eligibility.

In the performance of the coordinating function, the Service Coordinator will:
• Coordinate efforts in accordance with Department requirements and prompt the participant to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan.
• Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
─ Include people chosen by the participant for service plan meetings, review assessments, including discussion of needs, to gain understanding of the participant's preferences, suggestions for services and other activities key to ensure a participant-centered service plan.
─ Provide necessary information and support to ensure that the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
─ Be timely and occur at times and locations of convenience to the participant.
─ Reflect cultural considerations of the participant.
─ Include strategies for solving conflict or disagreement within the process.
─ Offer choices to the participant regarding the services and supports they receive and the providers who may render them.
─ Inform participants of the method to request updates to the service plan.
─ Ensure and document the participant's participation in the development of the service plan.
• Develop and update the service plan in accordance with Appendix D, based upon the standardized needs assessment and participant-centered planning process annually, or more frequently as needed.
• Explore coverage of services to address participant identified needs through other sources, including services provided under the State Plan, Medicare and/or private insurance or other community resources. These resources shall be used until the plan limitations have been reached or a determination of non-coverage has been established and prior to any service's inclusion in the service plan, in accordance with Department standards.
• Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the participant, including HealthChoices care coordinators, to ensure seamless coordination between physical, behavioral and support services.
• Coordinate with providers and potential providers of services to ensure seamless service access and delivery.
• Coordinate with the participant's family, friends and other community members to cultivate the participant's natural support network, to the extent that the participant (adult) has provided permission for such coordination.

In the performance of the monitoring function, the Service Coordinator will:
• Ensure that services are furnished in accordance with the ISP.
• Ensure that services meet participant needs.
• Monitor the health, welfare and safety of the participant and service plan implementation through regular contacts (monitoring visits with the participant, paid and unpaid caregivers and others) at a minimum frequency as required by the Department.
• Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare and safety of the participant in accordance with Appendix G.
• Monitor the effectiveness of back-up plans.
• Review provider documentation of service provision and monitor participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes.
• Through the service plan monitoring process, solicit input from participant and/or family, as appropriate, related to satisfaction with services.
• Arrange for modifications in services and service delivery, as necessary, to address the needs of the participant, consistent with

an assessment of need and Department requirements, and modify the service plan accordingly.
• Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and participant rights.
• Participate in any Department identified activities related to quality oversight.
Service Coordination includes functions necessary to facilitate community transition for participants who received Medicaid-funded institutional services (i.e. Nursing Facilities) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Service Coordination activities for participants leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community. Providers may not bill for this service until the date of the person's entry into the waiver program

Service Coordination entities must use an information system as approved and required by the Department to maintain case records in accordance with Department requirements.
Services must be delivered in a manner that supports the participant's communication needs, including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Coordination is limited to 144 units over a 12-month period. However, in order to meet the varying needs of individuals for service coordination services, this service limitation may be waived when reviewed and approved by OLTL.

The following activities are excluded from Service Coordination as a billable waiver service:
• Outreach or eligibility activities (other than transition services) before participant enrollment in the waiver.
• Travel time incurred by the Service Coordinator may not be billed as a discrete unit of service.
• Services that constitute the administration of another program such as protective services, parole and probation functions, legal services, and public guardianship.
• Representative payee functions.
• Other activities identified by the Department.

Service Coordination must be conflict free and may only be provided by agencies and individuals employed by agencies who are not:
• Related by blood or marriage to the participant or to any paid service provider of the participant
• Financially or legally responsible for the participant.
• Empowered to make financial or health-related decisions on behalf of the participant.
• Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant.
• Individuals employed by agencies paid to render direct or indirect services (as defined by the Department) to the participant, or an employee of an agency that is paid to render direct or indirect services to the participant.

Claims for costs incurred on behalf of participants transitioning from an institutional setting may only be paid after the transition to the community.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Service Coordination Entity

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Service Coordination

Provider Category:
Agency
Provider Type:
Service Coordination Entity
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Service Coordination Entities must:
• Comply with 55 PA Code 1101 and have a waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Meet the conflict free requirements pursuant to 55 PA Code, Chapter 52, §52.28;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs;
• Comply with and meet all standards as applied through each phase of the standard, annual Department performed monitoring process;
• Ensure 24-hour access to Service Coordination personnel (via direct employees or a contract) for response to emergency situations that are related to the Service Coordination service or other waiver services;
• Sufficient professional staff to perform the needed assessment/reevaluation, service coordination and support activities; and
• Registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement.
Service Coordinators must meet the following:
• Be at least 18 years of age;
• Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Service Coordination Supervisors must meet the following:
• Be at least 18 years of age;
• Meet the qualification and training requirements pursuant to PA Code, Chapter 52, §52.27;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Structured Day Habilitation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Structured Day Habilitation Services include supervision, training, and support to allow the participant to attain his or her maximum potential. Services include social skills training, sensory/motor development, and reduction/elimination of maladaptive behavior. Services are directed at preparing the participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Structured Day Habilitation Services take place in small group settings. Effective July 1, 2014, services must be separate from the participant's private residence or other residential living arrangement. The provider must operate Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of participants is not Medicaid reimbursable.

Staff to Client Ratios
• One direct care staff to 8 clients during activities
• One other individual must always be present

Structured Day Habilitation Providers that also provide Residential Habilitation are required to provide transportation to Structured Day Habilitation Services as part of Residential Habilitation Services. Structured Day Habilitation Providers are

required to provide transportation to community-based activities that are provided as part of the Structured Day Habilitation service.

Meals are not included with the delivery of this service. Participants are responsible to bring their own meals and snacks.

OLTL will consider enhanced staffing levels for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. These individuals, by the nature of their behaviors, are not able to participate in activities or are unable to access the community without direct staff support. Enhanced Structured Day Habilitation Services is an add-on to the Structured Day Habilitation Services and is only available when participants require additional behavioral supports.

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:
• Level 1: staff-to-individual ratio of 1:1.
• Level 2: staff-to-individual ratio of 2:1 or greater.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Billing for Structured Day Habilitation:
Structured Day Habilitation Services do not include: 1:1 therapies (OT, PT, ST, Cognitive Rehabilitation Therapy, and Behavior Therapy), adult daily living, job coaching, employment skills development, personal assistance services or community integration. These services are available to participants receiving Structured Day Habilitation Services as indicated in the needs assessment and documented on the Individual Service Plan, but may not be provided simultaneously. Structured Day Habilitation Services also do not include competitive employment or higher education courses.
Transportation can be included as a separate service as indicated on the needs assessment and documented on the ISP for participants that are not also receiving Residential Habilitation Services.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's Individual Service Plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Structured Day Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Structured Day Habilitation Services

Provider Category:
Agency
Provider Type:
Structured Day Habilitation Agency
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
By July 1, 2014 those providing structured day services must achieve CARF Community Integration accreditation, or CARF Brain Injury Home and Community Services (Adult) accreditation, or be licensed under 55 Pa Code, Chapter 2380 as an Adult Training Facility.
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of

the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Commercial General Liability Insurance
• Have Professional Liability Errors and Omissions Insurance
• Have Worker's Compensation Insurance in accordance with State statute and in accordance with Department policies.
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavior needs.
• Necessary staff, may include independent education instructors, speech therapists, physical therapists, occupational therapists, behavior therapists or cognitive rehabilitation therapists or other staff, to meet participant needs as outlined in the participant's service plan.
All individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs
• Complete initial Structured Day Habilitation Service Training within 6 months of being hired, which consists of a minimum of 20 hours of brain injury specific training.
• Complete a minimum of 12 hours of Ongoing Structured Day Habilitation Training annually.
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
• Have a child abuse as per 23 Pa. C.S. Chapter 63
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

In addition to the general standards listed above, Individual Support Staff must:
• Be at least 18 years of age
• Have a high school diploma or GED and have a minimum of five (5) years' experience working with people with disabilities, or
• Have a Bachelor's degree in a human service field.
• Staff employed to provide Enhanced Structured Day Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually
• Provide assistance in therapeutic and structured group and individual activities, and assistance as required with ADLs.
• Implement treatment plans, monitor individual and group progress, and document and records progress of participants served.

In addition to the general standards listed above, Independent Education Instructors must:
• Hold a Bachelor's degree with a current teaching certificate
• Have two years of experience teaching basic adult education
• Be certified under the Department of Education
Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.
In addition to the general standards listed above, Cognitive Rehabilitation Therapists must:
• Be a licensed Occupational Therapist under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board) or
• Be a licensed psychologist licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41 or
• Be a licensed social worker licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49 or
• Be a licensed professional counselor licensed by the state of Pennsylvania as a Professional Counselor with a Master's degree or a doctorate from a CACREP-approved academic program, passed the National Counselor Examination (NCE), and completed at least 3 years or 3,600 hours of supervised clinical experience.
• Individuals with a bachelor's or master's degree in communication disorders, counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, or special education who are not licensed or certified may practice under the supervision of a practitioner who is licensed.
Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.
In addition to the general standards listed above, Speech Therapists must:
• Be licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)
• Have certification as required by 42CFR Part 484
• Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, Occupational Therapists or Occupational Therapy Assistants must:
• Be licensed under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board)
• Have certification as required by 42 CFR Part 484
• Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, Physical Therapists or Physical Therapy Assistants must:
• Be licensed under PA Department of State, per 49 PA Code Chapter 40 (Physical Therapy Licensing Board)
• Have certification as required by 42CFR Part 484
• Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, professionals providing Behavior Therapy must:
• Be a licensed psychologist - Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41 or
• Be a licensed Social Worker - Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49 or
• Be a licensed Behavior Analyst – Licensed by the State Board of Medicine, per 49 Pa, Code §§ 18.521 - 18.527or
• Be a licensed Professional Counselor - licensed by the state of Pennsylvania as a Professional Counselor with a Master's degree or a doctorate from a CACREP-approved academic program, passed the National Counselor Examination (NCE), and completed at least 3 years or 3,600 hours of supervised clinical experience

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Behavior Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

- (●) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Effective July 1, 2016, Behavior Therapy Services are a separate and distinct service; they were previously included under the service definition of Therapeutic and Counseling Services.

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

Behavior Therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior Therapy services are provided by a licensed psychologist, licensed social worker, licensed behavior specialist, licensed professional counselor, or a home health agency that employs them. Individuals with a master's degree in social work, psychology, education, counseling, or a related human services field who are not licensed or certified may practice under the supervision of a practitioner who is licensed.

If there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan, through the Office of Mental Health and Substance Abuse Services, will cover the visit outside of the home and community-based services waiver up to pre-specified limits. Behavior Therapy services are utilized only when no diagnosis is present or the service is deemed to not be medically necessary or not making meaningful progress under State Plan standards.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participants must access State Plan services, including Outpatient Psychiatric Clinic Services, Outpatient Drug and Alcohol Services and services through the Behavioral Health Managed Care Organizations before accessing Behavior Therapy services through the Waiver.

Behavior Therapy Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or a responsible third party, such as Medicare or private insurance, unless the required expertise and experience specific to the disability is not available through the Medicaid State Plan or private insurance providers. This may be because the Medicaid State Plan, Medicare or insurance limitations have been reached, or the service is not covered under the Medicaid State Plan, Medicare or private insurance, or the provider does not have the expertise or experience specific to the disability. This waiver service is only provided to individuals age 21 and over. All medically necessary Behavior Therapy services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

The Service Coordinator is responsible for verifying and documenting in the participant's file that the Medicaid State Plan and private insurance limitations have been exhausted or that the Medicaid State Plan or private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Behavior Specialist
Individual	Licensed Professional Counselor
Individual	Licensed Social Worker
Individual	Licensed Psychologist

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Behavior Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Behavior Specialist
Provider Qualifications
License *(specify)*:
Licensed by the State Board of Medicine, per 49 Pa, Code §§ 18.521 - 18.527
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/ PA State Board of Medicine
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Behavior Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Professional Counselor
Provider Qualifications
License *(specify)*:
Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;

Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Behavior Therapy Services

Provider Category:
Individual

Provider Type:
Licensed Social Worker

Provider Qualifications

License *(specify)*:
Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Behavior Therapy Services

Provider Category:
Individual

Provider Type:

Licensed Psychologist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Comply with all Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA State Board of Psychology Professional Psychologists

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Behavior Therapy Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

Agency:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for or contracted with agencies must meet the following standards:
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under

Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Effective July 1, 2016, Nursing Services are a separate and distinct service; they were previously included under the service definition of Home Health Services.

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

Nursing services must be performed by a Registered Nurse or Licensed Practical Nurse. 49 PA Code Chapter 21 (State Board of

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

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

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

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance. This waiver service is only provided to individuals age 21 and over. All medically necessary Nursing services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.

Service is limited to needs determined during the assessment and identified in the participant's service plan.

Long-term or continuous nursing cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, Residential Habilitation Services or Respite Services. Short-term or intermittent nursing can be provided simultaneously with Residential Habilitation Services.

The most appropriate level of staffing, as determined by the assessment, must be used for a task.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Nursing Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:
Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy

Category 2: **Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Effective July 1, 2016, Occupational Therapy Services are a separate and distinct service; they were previously included under the service definition of Home Health Services.

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

Occupational Therapy services must address an assessed need documented in the participant's service plan. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Occupational Therapy services authorized in the service plan.

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

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational Therapy services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance. This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.
Service is limited to needs determined during the assessment and identified in the participant's service plan.
The most appropriate level of staffing, as determined by the assessment, must be used for a task.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Health Agency
Agency	Out-Patient or Community-Based Rehabilitation Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

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

Certificate *(specify)*:
Certification as required by 42CFR Part 484

Other Standard *(specify)*:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of State Occupational Therapy and Education Licensing Board

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:
Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:

Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Must hold an appropriate active license in the State of Pennsylvania;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Physical Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Effective July 1, 2016, Physical Therapy Services are a separate and distinct service; they were previously included under the service definition of Home Health Services.

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

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

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

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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

Physical Therapy services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance. This waiver service is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.
Service is limited to needs determined during the assessment and identified in the participant's service plan.
The most appropriate level of staffing, as determined by the assessment, must be used for a task.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Home Health Agency
Agency	Out-Patient or Community-Based Rehabilitation Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy Services

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

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

Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of State Physical Therapy Licensing Board
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications

License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:
Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:
Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Must hold an appropriate active license in the State of Pennsylvania;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of Health

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant's disability. These services or items are necessary to ensure health, welfare and safety of the participant and enable the participant to function in the home and community with greater independence. This service is intended to enable participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the participant's service plan and determined necessary in accordance with the participant's assessment.

Specialized Medical Equipment and Supplies includes:
• Devices, controls or appliances, specified in the service plan, that enable participants to increase, maintain or improve their ability to perform activities of daily living.
• Equipment repair and maintenance, unless covered by the manufacturer warranty
• Items that exceed the limits set for Medicaid State plan covered services
• Rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment and Supplies
Non-Covered Items:
• All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
• Items covered under third party payer liability
• Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability
• Food, food supplements, food substitutes (including formulas), and thickening agents;
• Eyeglasses, frames, and lenses;
• Dentures
• Hearing Aids
• Any item labeled as experimental that has been denied by Medicare and/or Medicaid
• Recreational or exercise equipment and adaptive devices for such
All items shall meet applicable standards of manufacture, design and installation.
If the participant receives Speech, Occupational, or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Specialized Medical Equipment and Supplies, the Specialized Medical Equipment and Supplies must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Medical Equipment and Supplies may only be funded through the waiver when the services are not covered by the State Plan, EPSDT or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan, EPSDT or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable. This waiver service is only provided to individuals age 21 and

over. All medically necessary Specialized Medical Equipment services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

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

Specialized Medical Equipment and Supplies exclude Assistive Technology.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Durable Medical Equipment
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications

• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Pharmacy
Provider Qualifications

License *(specify)*:
Permit to conduct a pharmacy, under 49 PA Code, Part I, Subpart A. Chapter 27
Certificate *(specify)*:
Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of State
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Effective July 1, 2016, Speech and Language Therapy Services are a separate and distinct service; they were previously included under the service definition of Home Health Services.

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

Speech and Language Therapy Services must address an assessed need as documented in the participant's service plan. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. The therapist is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Speech and Language Therapy services authorized in the service plan.

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

The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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

Speech and Language Therapy services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance. This waiver service is only provided to individuals age 21 and over. All medically necessary Speech and Language Therapy services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

Service Coordinators must seek coverage of services provided under the State Plan, Medicare and/or private insurance plans until the plan limitations have been reached, prior to requesting services in the service plan.
Service is limited to needs determined during the assessment and identified in the participant's service plan.
The most appropriate level of staffing, as determined by the assessment, must be used for a task.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech Therapist
Agency	Home Health Agency
Agency	Out-Patient or Community-Based Rehabilitation Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Therapy Services

Provider Category:
Individual
Provider Type:
Speech Therapist
Provider Qualifications
License *(specify)*:
Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)
Certificate *(specify)*:
Certification as required by 42CFR Part 484
Other Standard *(specify)*:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of State Language and Hearing Examiner's Board
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Therapy Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance; and
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
Individuals working for agencies must meet the following standards:
Be at least 18 years of age;
Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Therapy Services

Provider Category:
Agency
Provider Type:
Out-Patient or Community-Based Rehabilitation Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications,

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the participant, as specified in the participant's individual service plan (ISP) and determined necessary in accordance with the participant's assessment. The service is intended to ensure the health, welfare and safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities.
Assistive Technology includes supports to a participant in the selection, acquisition or use of an Assistive Technology device. Training to utilize adaptations, modifications and devices is included in the purchase, as applicable. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.
Assistive Technology is limited to:
• Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for participants
• Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device
• Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings
• Training or technical assistance for the participant, paid caregiver and unpaid caregiver
• An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment
• Extended warranties
• Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist participants with a need identified through the evaluation described below
All items shall meet the applicable standards of manufacture, design and installation.
If the participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service.

The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistive Technology services may only be funded through the waiver when the services are not covered by another responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable. This waiver service is only provided to individuals age 21 and over. All medically necessary Assistive Technology services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

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

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Durable Medical Equipment
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
• Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professional must be a graduate of a Department approved Rehabilitative Sciences program that is Certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or a Rehabilitative Sciences degree with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities.

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Contractor
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (A company that the provider secures the item(s) from can be located anywhere)
• Adhere to all applicable local and State codes
• Have Commercial General Liability Insurance
• Have Workers Compensation Insurance, in accordance with State statute
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCDS
Frequency of Verification:
Upon purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Cognitive Rehabilitation Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Effective July 1, 2016, Cognitive Rehabilitation Therapy Services are a separate and distinct service; they were previously included under the service definition of Therapeutic and Counseling Services.

Cognitive Rehabilitation Therapy Services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Services are provided by an occupational therapist,
licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them. Individuals with a bachelor's or master's degree in communication disorders, counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, or special education who are not licensed or certified may practice under the supervision of a practitioner who is licensed. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Cognitive Rehabilitation Therapy Services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing.

This waiver service is only provided to individuals age 21 and over. All medically necessary Cognitive Rehabilitation Therapy services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cognitive Rehabilitation Therapy Services may only be funded through the waiver when the service is not covered by another responsible third party, such as Medicare or private insurance, unless the required expertise and experience specific to the disability is not available through the private insurance providers. This may be because Medicare or insurance limitations have been reached, or the service is not covered under Medicare or private insurance, or the provider does not have the expertise or experience specific to the disability.

The Service Coordinator is responsible for verifying and documenting in the participant's file that private insurance limitations have been exhausted or that the private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Licensed Psychologist
Individual	Occupational Therapist
Individual	Speech and Language Therapist
Agency	Home Health Agency
Individual	Licensed Professional Counselor
Individual	Licensed Social Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Psychologist
Provider Qualifications
License *(specify)*:
Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Comply with all Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA State Board of Psychology Professional Psychologists
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify)*:

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:

PA Department of State Occupational Therapy and Education Licensing Board

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:

Individual

Provider Type:

Speech and Language Therapist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certification as required by 42CFR Part 484

Other Standard *(specify):*

Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of State Language and Hearing Examiner's Board

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
Agency:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

Individuals working for or contracted with agencies must meet the following standards:
• Be 18 years of age or older;
• Possess basic math, reading and writing skills;
• Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
• Have the required skills to perform services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan;
• Possess a valid Social Security number;
• Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Professional Counselor
Provider Qualifications
License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance in accordance with Department policies;
• Be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Integration is a short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a nursing facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participant's service plan.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the participant to assure that expected outcomes are met and the service plan is modified accordingly.

Services must be provided at a 1:1 ratio.

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

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

Community Integration is reviewed quarterly to determine the progress of how the strategies utilized are affecting the participant's ability to independently complete tasks identified in the ISP. If the individual can complete the task independently, then the goal and CI service should be removed from the ISP. The length of service should not exceed thirteen (13) weeks on new plans.

If the participant has not reached the goal at the end of 13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the ISP at the time of the quarterly review.

If the participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the SC must assess for a more appropriate service to meet the individual's need.

Each distinct goal may not remain on the ISP for more than twenty-six (26) weeks.

No more than 32 units per week for one CI goal will be approved in the ISP. If the participant has multiple CI goals, no more than 48 units per week will be approved in the ISP.

OLTL retains the discretion to 1) authorize CI for individuals who have not experienced a "life-changing event"; and 2) authorize more than 48 units (12 hours) of CI in one week for up to 21 hours per week and for periods longer than 26 weeks.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:
Agency
Provider Type:
Community Integration Agency
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Professional Liability Errors and Omissions Insurance, and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
• Individuals working for or contracted with agencies must meet the following standards: Be 18 years of age or older;
• Have a high school diploma or GED
• Have a minimum of six months of paid or volunteer experience in working with people with physical disabilities and/or older adults

• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
• Have the required skills to perform the Community Integration services specified in the participant's service plan;
• Possess a valid Social Security number; and
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have child abuse clearance as per 23 Pa. C.S. Chapter 63.

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL

Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The service must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure health, welfare and safety of the participant.

Community Transition Services may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:
• Equipment, essential furnishings and initial supplies. Examples—e.g. household products, dishes, chairs, tables;

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Service Provider
Individual	Independent Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Transitional Service Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and

• Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCDS
OLTL

Frequency of Verification:
OHCDS - Upon Purchase and Annually thereafter
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual

Provider Type:
Independent Vendor

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
• Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design and installation.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCDS or OLTL

Frequency of Verification:
OHCDS - Upon Purchase and Annually thereafter
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Counseling Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Effective July 1, 2016, Counseling Services are a separate and distinct service; they were previously included under the service definition of Therapeutic and Counseling Services.

Counseling Services are services that assist individuals to improve functioning and independence, and are necessary to improve the individual's inclusion in their community. Services are provided by a licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

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

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

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

Counseling Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or a responsible third party, such as Medicare or private insurance, unless the required expertise and experience specific to the disability is not available through the Medicaid State Plan or private insurance providers. This may be because the Medicaid State Plan, Medicare or insurance limitations have been reached, or the service is not covered under the Medicaid State Plan, Medicare or private insurance, or the provider does not have the expertise or experience specific to the disability. This waiver service is only provided to individuals age 21 and over. All medically necessary Counseling services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

The Service Coordinator is responsible for verifying and documenting in the participant's file that the Medicaid State Plan and private insurance limitations have been exhausted or that the Medicaid State Plan or private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Licensed Psychologist
Individual	Licensed Social Worker
Individual	Licensed Professional Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51
Certificate *(specify)*:
Certification as required by 42CFR Part 484
Other Standard *(specify)*:
Agency:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;

Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:
Individual
Provider Type:
Licensed Psychologist
Provider Qualifications

License *(specify):*
Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41
Certificate *(specify):*
N/A
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Comply with all Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA State Board of Psychology Professional Psychologists
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:
Individual
Provider Type:
Licensed Social Worker
Provider Qualifications
License *(specify):*
Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49
Certificate *(specify):*
N/A
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:
Individual
Provider Type:
Licensed Professional Counselor
Provider Qualifications
License *(specify):*
Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49
Certificate *(specify):*
N/A
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;

Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
Have a child abuse clearance (as per 23 PA C.S. Chapter 63).

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Adaptations are physical adaptations to the private residence of the participant, as specified in the participant's individual service plan (ISP) and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations.

Adaptations to a household are limited to the following:

• Ramps from street, sidewalk or house
• Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Durable Medical Equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Adaptations

Provider Category:
Individual
Provider Type:
Contractor
Provider Qualifications
License *(specify)*:
Contractor's license for the State of Pennsylvania or a state contiguous to Pennsylvania, if required by trade.
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable.
• All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply
• Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license
• Compliance with the Pennsylvania Home Improvement Consumer Protection Act and other applicable standards

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs, if applicable.
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
service
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCDS or OLTL
Frequency of Verification:
OHCDS – At time of service
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Adaptations

Provider Category:
Agency
Provider Type:
Durable Medical Equipment
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable.
• All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply
• Organizations must have capacity to provide 24-hour coverage by trained professionals, 365 days/year
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Be a Licensed Contractor
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCDS or OLTL
Frequency of Verification:
OHCDS – At time of service
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1: 15 Non-Medical Transportation

Sub-Category 1: 15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Non-Medical Transportation services are offered in order to enable participants to gain access to waiver services as specified in the individualized service plan. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must be tied to a specific objective identified on the participant's service plan.

The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Medical Assistance Transportation Program (MATP) services will be used for obtaining State Plan services. The participant's service plan must document the need for those Non-medical Transportation services that are not covered under the Medical Assistance Transportation Program.

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

Non-Medical Transportation does not cover reimbursement to the participant or another individual when driving the participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs.

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Licensed Transportation Agency, Public Transit Authority
Provider Qualifications
License *(specify):*
Licensed by the P.U.C and/or be a Public Transit Authority, a Community Transportation Provider or Community Transportation Subcontractor
Certificate *(specify):*
N/A
Other Standard *(specify):*
Agencies must:
• Meet PA Vehicle Code (Title 75);
• Have Commercial General Liability insurance;
• Have automobile insurance for all automobiles owned, leased and/or hired and used to provide the Transportation service;
• Have Workers' Compensation insurance in accordance with State statute;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, which includes, but is not limited to, communication, mobility and behavioral needs; and
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52.
Drivers employed by licensed transportation agencies and public transit authorities must meet the following:
• be at least 18 years of age;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15;
• Have child abuse clearance (as per 23 Pa. C.S. Chapter 63);
• Agree to carry out the Transportation outcomes included in the participant's service plan; and
• Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCDS
OLTL
Frequency of Verification:
OHCDS verifies provider qualifications prior to service approval; annually thereafter
OLTL monitors the OHCDS every two years

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Individual Driver
Provider Qualifications
License *(specify):*
Valid Pennsylvania driver's license appropriate to the vehicle
Certificate *(specify):*

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

Other Standard *(specify):*

Drivers must meet the following:

• 18 years of age;
• Must have appropriate insurance coverage ($100,000/$300,000 bodily injury);
• Have automobile insurance for all automobiles used to provide the Transportation service;
• Vehicles must be registered with the PA Department of Transportation;
• Receive a physical examination (including a vision test) at the time of hire and at least every 2 years; and
• Be willing to provide door-to-door services.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDS
OLTL

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Effective July 1, 2016, Nutritional Consultation Services are a separate and distinct service; they were previously included under the service definition of Therapeutic and Counseling Services.

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

Nutritional Consultation assists the participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant, caregiver and any providers in the implementation of the plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home Health Agencies that employ licensed and registered dieticians may provide nutritional counseling.

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

Nutritional Consultation Services may only be funded through the waiver when the service is not covered by another responsible third party, such as Medicare or private insurance. This may be because Medicare or insurance limitations have been reached, or the service is not covered under Medicare or private insurance. This waiver service is only provided to individuals age 21 and over. All medically necessary Nutritional Consultation services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Dietitian or a Certified Nutrition Specialist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51
Certificate *(specify)*:
Certification as required by 42CFR Part 484

Other Standard *(specify):*
Agency:
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability Insurance;
• Have Professional Liability Errors and Omissions Insurance;
Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs; and
Provide staff training pursuant to 55PA Code Chapter 52, Section 52.21.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/PA Department of Health
Frequency of Verification:
At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:
Individual
Provider Type:
Registered Dietitian or a Certified Nutrition Specialist
Provider Qualifications

License *(specify):*
Licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21, subchapter G
Certificate *(specify):*
N/A
Other Standard *(specify):*
Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
Have Commercial General Liability insurance in accordance with Department policies;
Be at least 18 years of age;
Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
Title 49 PA Code Ch. 21 Subchapter G relates to the general provisions, licensure requirements and the

responsibilities of the licensed dietician-nutritionist issued under sections 2.1(k) and 11(c) of the Professional Nursing Law (63 P. S. § 212(k) and 221(c).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL/PA Department of State Board of Dietitian-Nutritionists

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device which enables waiver participants to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year.

PERS services are limited to those individuals who:

• Live alone.

• Are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances.

• Live with an individual that may be limited in their ability to access a telephone quickly when a participant has an emergency.

• Would otherwise require extensive in-person routine monitoring and assistance. Installation, repairs, monitoring and maintenance are included in this service.

The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is not covered in the State Plan. Participants can only receive PERS services when they meet eligibility criteria specified in accordance with Department standards, and the services are not covered under Medicare or other third-party resources.

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

Installation is covered one time per residential site.

Stand-alone smoke detectors will not be billed under PERS.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
Durable Medical Equipment and Supply Company
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
Individuals working for or contracted with agencies must meet the following standards:

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/OHCDS
Frequency of Verification:
OHCDS - Upon Installation and Annually thereafter
OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications

License *(specify):*
Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart G. Chapter 601 and Subpart A Chapter 51
Certificate *(specify):*
Certification as required by 42CFR Part 484
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL/OHCDS
Frequency of Verification:
OHCDS - Upon Installation and Annually thereafter
OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:
Vendors of Personal Emergency Response Systems
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• All PERS installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply, including any applicable business license; and
• Organization must have capacity to provide 24-hour coverage by trained professionals, 365 days/year.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.
Verification of Provider Qualifications
Entity Responsible for Verification:
OLTL/OHCDS
Frequency of Verification:
OHCDS - Upon Installation and Annually thereafter
OLTL – At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Prevocational Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Prevocational services are services not available under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the individuals with Disabilities Education Act of 1973 [20 U.S.C. 1201 (16 and 17)]. Services are aimed at preparing an individual for paid or unpaid employment but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Prevocational services are provided to persons not expected to be able to join the work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

• Activities included in this service are not primarily directed at teaching skills, but at underlying goals directed at assisting the consumer towards greater independence, such as improving attention span and motor skills.
• When compensated, individuals are paid at less than 50 percent of the minimum wage.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Vocational Facility
Provider Qualifications
License *(specify):*
55 PA Code Chapter 2390
Certificate *(specify):*
N/A
Other Standard *(specify):*

• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Possess a valid Social Security number;
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:
DHS and OLTL
Frequency of Verification:
DHS – Annually
OLTL – At least every two years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported Employment Services are paid employment services for persons for whom competitive employment at or above the minimum wage is unlikely, and who because of their disability need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training of the individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.

Supported Employment is provided on a 1:1 basis.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
When Supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
• Payments that are passed through to users of Supported employment programs; or
• Payments for training that is not directly related to an individual's Supported employment program.

Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.
This service may not exceed eight (8) hours per day.
The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment Agency

Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Have Professional Liability Errors and Omissions Insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs

Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Have a high school diploma or GED and six months of paid or volunteer experience in working with people with physical disabilities and/or older adults
• Have the required skills to perform the Supported Employment services specified in the participant's service plan
• Have completed a service specific training program related to goals in the participant's service plan
• Possess a valid Social Security number;
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:
OLTL
Frequency of Verification:
Every Two Years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

Category 2: **Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community. The following are specifically excluded:
• Modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant
• Purchase or lease of a vehicle with or without existing adaptations
• Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications
The waiver cannot be used to purchase vehicles for participants, their families or legal guardians. Vehicle Modifications funded through the waiver are limited to the following:
• Vehicular lifts
• Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle
• Interior alterations to seats, head and leg rests and belts
• Customized devices necessary for the participant to be transported safely in the community, including driver control devices
• Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions
• Raising the roof or lowering the floor to accommodate wheelchairs
• The vehicle must be less than 5 years old, and have less than 50,000 miles for vehicle modification requests over $3,000
All Vehicle Modifications shall meet applicable standards of manufacture, design and installation.
The provision of this service may be facilitated by an OHCDS as described in Appendix I.3.g.ii.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A vehicle is required to have passed all applicable State standards.
This service does not include, but requires, an independent evaluation. Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate.
The vehicle that is modified may be owned by the participant, a family member with whom the participant lives, or a non-relative who provides primary support to the participant and is not a paid provider agency of services. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Vehicle Modifications Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
Vehicle Modifications Contractor
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
Quality Assurance Program (QAP) Accreditation by the National Mobility Equipment Dealers Association (NMEDA).
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a waiver provider agreement
• Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
• Have Commercial General Liability insurance
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
• Adhere to all applicable local and State codes
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age
• Comply with all Department standards including regulations, policies and procedures related to provider qualifications
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCDS or OLTL
Frequency of Verification:
OHCDS - At time of service
OLTL - At least every two (2) years and more frequently when deemed necessary by the Department

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

Criminal history checks are required for all support service workers and must be conducted in accordance with 55 PA Code, Chapter 52, Sections 52.19 and 52.20. Individuals choosing to self-direct their services have the right to employ a worker regardless of the outcome of the background check. Support service workers who are employed by waiver participants must have criminal history clearances completed prior to hire, facilitated through the FEA as described below, so that participants can make an informed decision on whether to employ a worker who has a criminal record.

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

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

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

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

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

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Clearances are required for all direct care workers and service providers, including service coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.
The following three certifications must be obtained prior to providing services in homes where children reside:
• Report of criminal history from the Pennsylvania State Police (PSP);
• Fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and
• Child Abuse History Certification from the Department of Human Services (Child Abuse).
Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called "Pennsylvania Access To Criminal History" (PATCH), at https://epatch.state.pa.us, or by submitting the "Request For Criminal Record Check" form SP4-164 (updated 7/2015) to the following address: Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (717) 425-5546.
The Department of Human Services is utilizing Cogent Systems to process fingerprint-based FBI record checks. The fingerprint based background check is a multiple step process. The Cogent Systems Web site https://www.pa.cogentid.com/index_dpwNew.htm allows individuals to apply online, as well as provide detailed information regarding the application process.
Child Abuse History Certifications are obtained online at http://www.compass.state.pa.us/CWIS, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.
For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant's home. Workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.
Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015, must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.
If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of the third degree and shall be subject to discipline up to and including termination or denial of employment.
The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, shall maintain copies of the required information
The F/EA is responsible for securing clearances for prospective support service workers. The cost of conducting clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the clearances were conducted.
OLTL reviews provider personnel records as part of the biennial monitoring to ensure that the clearances are conducted and documented as referenced in the Quality Improvement section. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.

Appendix C: Participant Services

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

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

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

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

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

Facility Type	
Personal Care Home	
Assisted Living Residence	

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

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response System	☐
Nursing Services	☐
Personal Assistance Services	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Counseling Services	☐
Assistive Technology	☐
Community Transition Services	☐
Nutritional Consultation	☐
Home Adaptations	☐
Residential Habilitation Services	☑
Cognitive Rehabilitation Therapy Services	☐
Non-Medical Transportation	☐
Behavior Therapy Services	☐
Speech and Language Therapy Services	☐
Supported Employment	☐
Service Coordination	☐
Adult Daily Living	☐
Respite	☑
Prevocational Services	☐
Structured Day Habilitation Services	☐
Vehicle Modifications	☐
Occupational Therapy	☐
Community Integration	☐

Facility Capacity Limit:

8

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	

Standard	Topic Addressed
	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response System	☐
Nursing Services	☐
Personal Assistance Services	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Counseling Services	☐
Assistive Technology	☐
Community Transition Services	☐
Nutritional Consultation	☐
Home Adaptations	☐
Residential Habilitation Services	☑
Cognitive Rehabilitation Therapy Services	☐
Non-Medical Transportation	☐
Behavior Therapy Services	☐
Speech and Language Therapy Services	☐
Supported Employment	☐
Service Coordination	☐
Adult Daily Living	☐
Respite	☐
Prevocational Services	☐
Structured Day Habilitation Services	☐
Vehicle Modifications	☐
Occupational Therapy	☐

Waiver Service	Provided in Facility
Community Integration	☐

Facility Capacity Limit:

8

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

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

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

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

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

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

• The OBRA Waiver will not pay for services furnished by the participant's spouse.

• The OBRA Waiver will not pay for services furnished by a legal guardian.

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

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

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

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

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

Family members who provide Personal Assistance or Respite Services, like all providers, must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews authorized billable units through the Home and Community Based Services Information System (HCSIS). Reimbursement for services rendered is generated through the Provider Reimbursement Operations Management Information System (PROMISe).

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

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

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

○ **Other policy.**

Specify:

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

All willing and qualified providers have the opportunity to enroll as waiver providers at any time. OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available upon request from the OLTL, and are also available to potential providers online through the DHS website http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment report

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-2: Number and percent of providers continuing to meet applicable licensure/certification, regulatory and applicable waiver standards following initial enrollment Numerator: Number of providers who continue to meet required licensure and initial QP standards Denominator: Number of providers reviewed

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%

	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment database

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bi-Annually	

Data Aggregation and Analysis:

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

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

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%

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

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

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

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

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% + - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal Representatives. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator.

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

b. Methods for Remediation/Fixing Individual Problems

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

Subassurance a.i.a - Before a provider is enrolled as a qualified waiver provider, it must provide written documentation to the State Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or certified provider is required to submit written documentation that it meets regulatory and initial qualified waiver requirements that are not part of its licensure or certification. When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL issues a Statement of Findings as required by 55 Pa. Code Chapter 52. The provider is required to respond to the findings with a Corrective Action Plan (CAP) to remediate each finding. If a provider fails to submit a CAP which remediates the lack of licensure or certification requirement, OLTL begins disenrollment proceedings. The provider has the right to appeal.

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

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

The QMET verifies the approved CAP action steps are in place according to the timeframe as written the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:
   - ☐ **Social Worker**
     Specify qualifications:
   - ☐ **Other**
     Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. **Service Plan Development Safeguards.** *Select one:*
   - ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

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

Service Coordination agencies may facilitate the provision of the following services by serving as an Organized Health Care Delivery System (OHCDS).
• Community Transition Services;
• Personal Emergency Response System (PERS);
• Home Adaptations;
• Vehicle Modifications;
• Assistive Technology; and/or
• Non-medical Transportation

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

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver and their right to choose from and among all willing and qualified providers. Service Coordinators are also responsible for providing participants with information about the Services and Supports Directory - a web-based listing of all qualified and enrolled waiver providers – during the ISP development process. The information contained in the Services and Supports Directory will also be made available in a non-web-based format, as necessary or when requested. The Services and Supports Directory allows individuals receiving OLTL services, family members, service coordinators and the general public to access timely and up to date information on providers and services being offered in their area. In addition, Service Coordinators are responsible for obtaining the participant's signature on the Service Provider Choice form indicating they were fully informed of all available qualified providers and documenting receipt of the Service Provider Choice form in the participant's record. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Individual Service Plan (ISP) development process is a collaborative process between the participant and Service Coordinator that includes people chosen by the participant, provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions, is timely and occurs at times and locations of convenience to the individual, and reflect cultural considerations and communication needs of the individual. The Service Coordinator provides information to the individual in advance of the planning meeting so that he/she can make informed choices about their services and service delivery.

A key step in developing the ISP is to complete OLTL's standardized needs assessment, which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator reviews the information gathered with the participant, family, friends, advocates or others that are identified and chosen by the participant to be part of the service plan development process. If the participant uses an alternative means of communication or

if their primary language is not English, the process utilizes the participant's primary means of communication, an interpreter, or someone identified by the participant that has a close enough relationship with the participant to accurately speak on his/her behalf.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The individual service plan (ISP), contains essential information about the individual, which is used for planning, and implementing supports necessary for the participant to successfully live the life that they choose. ISP's are based on written assessments and other supplemental documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs. All service plans must be developed in accordance with 55 PA Code, Chapter 52.25 and 52.26.

The Commonwealth also expects that the person-centered service plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment, as well as what is important to the person with regard to preferences for the delivery of such supports. In order to make fully informed decisions, the Service Coordinator provides and reviews with the participant a standard packet of information developed by OLTL in advance of the ISP meeting. The packet contains information on participant rights and responsibilities, participant choice, applying for home and community-based services programs, the role of the Service Coordinator, participant complaints, appeals and fair hearings, how to connect to other community resources, and fraud and abuse.

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

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

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

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

The types of assessments that are conducted:
Part of the enrollment process involves the local Area Agency on Aging (AAA) assessor's completion of a level of care assessment tool to determine whether the participant meets the ICF/ORC level of care. In addition a physician completes a physician certification form which indicates the physician's level of care recommendation.

At the time of enrollment, the independent enrollment entity completes the OLTL's standardized needs assessment, which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator uses the information gathered from the level of care assessment and the standardized needs assessment to develop the participant's Individual Service Plan.

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

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

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

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

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

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

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

How responsibilities are assigned for implementing the plan:
SCs are responsible for addressing and documenting the following information in the ISP to meet the requirements of OLTL for approval and implementation:
• OLTL services reflect identified unmet needs
• Participant's goals, strengths, and capabilities
• Coordination of waiver/program and non-waiver/program services
• Justification of services
• Preferences addressed
• Third Party Liability
• Informal Supports
• Community resources
• Any barriers/risks
• Assignment of responsibilities to implement and monitor the plan

• Individual back-up plan
• Emergency back-up plan
• Freedom of choice of service alternatives
• Choice of providers is offered
• Chosen service model
• Chosen providers
• Review of rights and responsibilities
• Contact with the participant, families and providers in service/journal notes
• Individuals who participated in the development of the ISP
• The frequency and duration of all services

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

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

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

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

How waiver and other services are coordinated:
A team consisting of the participant, Service Coordinator, and others of the participant's choosing consider all other potential sources of coverage as part of the service plan development process. The team reviews for any service coverage that may be available under the State Plan or other possible Federal programs or non-governmental programs before utilizing waiver services. The team also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the person's health, safety and welfare in the most cost effective manner. All identified services, whether available through the waiver or other funding sources, are outlined in the participant's ISP, which is distributed by the Service Coordinator to the participant and providers of service. The Service Coordinator is responsible for ensuring that there is coordination between services in the ISP, including facilitating access to needed State Plan benefits, maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers. Justification for limitations and/or not utilizing non-waiver services must be documented in service notes. OLTL reviews service plans to ensure that non-waiver resources, including MA covered services including State Plan Covered Services, are documented on the participant's ISP.

The assignment of responsibility to monitor and oversee the implementation of the service plan:
Upon authorization of the ISP, the Service Coordination Entity forwards a copy of the OLTL Service Authorization Form to identified service providers. The Service Authorization Form provides detailed information regarding the type, scope, amount, duration, and frequency of the service authorized. Also included on the form are demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being rendered by the provider. The Service Coordinator must communicate service plan approval and changes to the participant and the appropriate service provider to ensure that service delivery is consistent with the approved ISP. The Quality Management

Efficiency Teams (QMET) review the service plan against participant records and claims at a minimum biennially to ensure that the type, scope, amount, duration and frequency of services is actually provided by the direct service provider. The QMET also review the service coordination notes to ensure that the Service Coordination Entity is monitoring that services are appropriately delivered. The appropriate delivery of services is a regulatory requirement of all service providers, and failure to deliver services as identified in the ISP result in a Statement of Findings and potential penalties against the provider including and up to disenrollment.

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

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

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

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

The individual service plan (ISP), contains essential information about the individual, which is used for planning, and implementing supports necessary for the participant to successfully live the life that they choose. ISP's are based on written assessments or other documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

The Service Coordinator will also describe any unique circumstances on the service plan. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant when identifying any risks or possible services that would assist the participant with addressing these risks. A specific service or combination of services may benefit the participant in these types of circumstances.

Emergency back up plans and priority arrangements to ensure the health, safety and welfare of the participant are developed and documented during the ISP development process. Emergency back up plans are also part of the ongoing service plan monitoring process at the Service Coordinator level. All participants are required to have individualized backup plans and arrangements to cover

services they need when the regularly scheduled service worker is not available. Strategies for back up plans may include the use of family and friends of the participants' choice and/or agency staff, based on the needs and preferences of the participant. If the backup plan fails, participants may utilize the agency model to provide emergency backup coverage to meet their immediate needs. The Service Coordinator may reach out to and utilize other home health or home care agencies for backup if necessary and document the details in the ISP. The Service Coordinator is responsible during regular monitoring to validate that the strategies and backup plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Service Coordinators to report disruptions of backup plans and strategies. The service plan assessment process includes the identification of potential risks to the participant. The Service Coordinator will discuss these potential risks with the participant and whomever the participant chooses to have present such as providers, the participant's family and friends during the development of the ISP. The Service Coordinator, participant and any other participant chosen individuals will identify strategies to mitigate such risks that will allow participants to live as they choose in the community while assuring their health and welfare. These strategies will be incorporated into the ISP. The Service Coordinator will also describe any unique circumstances on the service plan. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant when identifying any risks or possible services that would assist the participant with addressing these risks. A specific service or combination of services may benefit the participant in these types of circumstances.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services. Participants are free to change providers at any time by informing their Service Coordinator of the desire to make a change.

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

A current listing of enrolled providers is maintained by OLTL in the Services and Supports Directory. This listing is maintained in HCSIS and automatically updated as new providers are enrolled. The Services and Supports Directory is shared with participants by both the enrollment agency as well as service coordination providers.

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

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

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

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

OLTL staff reviews service plan information in the Home and Community Services Information System (HCSIS). Service Coordination providers are required to confirm in HCSIS that the standard OLTL Service Provider Form has been completed whenever the Service Coordination provider submits a plan creation or plan revision to OLTL.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OLTL reviews and approves all service plans. The Service Coordinator, in conjunction with the participant, is responsible to modify the ISP if the participant's needs change.

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

Service Coordinators are required to review and update the participants ISP at least once every 365 days and submit the annual review in HCSIS. OLTL reviews a representative sample of service plans as described in the Quality Improvement section of this Appendix. As stated above, OLTL ensures that participant's service plans are updated according to OLTL requirements and in a fashion that supports participant's health and welfare through the Service Coordination oversight process.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

• Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. The Service Coordinator is responsible for completing the Department approved Participant Monitoring Tool during at least one of the face to face visits during the year. During monitoring contacts the SC is responsible for discussing the following information with the participant and documenting the information in HCSIS service notes for review by OLTL:
o The participant is receiving the amount, frequency, and duration of services that are in the approved ISP.
o The participant is receiving the authorized services that are in the ISP.
o The participant is receiving the amount of support necessary to ensure health and safety.
o If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes
o There is no duplication of services including waiver and non-waiver services.
o Contacts with individuals, families and providers.

o Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP.
o That the recommended and chosen services are being implemented.
o That the back-up plan is effective and how often it has been used.

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

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

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

Additionally, the Quality Management Efficiency Teams monitor the following activities as being provided by the Service Coordination activity. These activities are listed requirements in 55 Pa. Code § 52.26 (service coordination services).
• Services furnished in accordance with the service plan;
• Participant access to waiver services identified in service plan;
• Participants exercise free choice of provider;
• Services meet participants' needs;
• Effectiveness of back-up plans;
• Participant health and welfare; and
• Participant access to non-waiver services in service plan, including health services.

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

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

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

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

b. Monitoring Safeguards. *Select one:*

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

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

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

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

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

Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS, or select any other enrolled qualified provider. The Service

Coordination provider cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency.

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all wiling and qualified providers. Service Coordinators are responsible for providing participants with a list of approved qualified providers from the Services and Supports Directory – a web-based listing of all qualified and enrolled waiver providers – to the participant during the ISP development process, and obtain the participant's signature on the Service Provider Choice form, indicating they were fully informed of all available qualified providers. The Services and Supports Directory allows individuals receiving OLTL services, family members, service coordinators and the general public to access timely and up to date information on providers and services being offered in their area. Completed Service Provider Choice forms are also maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H.

OLTL also provides a toll-free HelpLine for participants to report concerns about their provider. This toll-free HelpLine information is incorporated into the OLTL Service Provider Choice Form.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
SP 1: Number and percent of waiver participants with Individual Service Plans (ISPs) that address all of the participant's assessed needs (including health and safety risk factors). Numerator (N) = Number of waiver participants with Individual Service Plans (ISPs) that address all of the participant's assessed needs Denominator (D) = Total number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective service plan review

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

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP 2: Performance Measure: Number and percent of waiver participants with Individual Service Plans (ISPs) that address all of a participant's personal goals (through waiver or non-waiver services). Numerator (N) Number of waiver participants with Individual Service Plans (ISPs) that address all of a participant's personal goals Denominator (D) Total number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective Service Plan Review

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective service plan review

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
SP-4: Number and percent of waiver participants who are received authorized services in the type, scope, amount, frequency and duration specified in the Individual Service Plan (ISPs) Numerator: Number of waiver participants who are receiving services specified in the Individual Service Plan (ISP) Denominator: Total number of service plan reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective service plan review

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Twice per year

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM Data

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
SP-8: Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator: Number of waiver participants with documented evidence of opportunities Denominator: Total number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective service plan review

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

Data Aggregation and Analysis:

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

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

BPO staff reviews 100% of new ISPs and 100% of ISPs that have a 10% change in services using the guidelines specified in the OLTL Service Plan Review Protocol. This ongoing review is collected in the Service Plan Review Database where the data is aggregated monthly and quarterly for tracking and trending by the Service Plan (SP) Assurance Liaison in the Bureau of Quality and Provider Management (BQPM) The SP Assurance Liaison tracks the sample size to ensure a statistically valid sample using CMS sampling parameters has been reviewed The SP Assurance Liaison also performs a quarterly retrospective review of the ISPs reviewed by BPO in the previous three months using the same review criteria.

Data is pulled from the OLTL Complaint Database regarding complaints received about service plans. The SP Assurance Liaison monitors a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement.

The SP Assurance Liaison reviews data from the OLTL participant satisfaction surveys for questions # 12 and 13 for both New and Annual surveys, pertaining to participant's needs and goals, and delivery of services. 100% of returned surveys responses are monitored and aggregated three times per year.

Quarterly, the OLTL conducts a representative sample review of participants' authorized services and claims to determine if participants are receiving services in the type, amount and frequency specified in the ISP.

See Appendix H for more information on BQPM.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When ISPs are reviewed for compliance and non-compliance is noted, BQPM issues a Quality Improvement Plan (QIP) to the BPO to address the non-compliance. The BPO submits a plan to correct the non-compliance to BQPM within the prescribed timeframes. As part of the QIP, BPO may contact the SC agency to remediate and follow-up on the issue. The BPO may also provide technical assistance to aid in that remediation.
The following language was added based on additional CMS RAI questions: As a part of OLTL's process during plan reviews, the plan reviewers review the plan for risk factors, identified needs, and personal choice reflected in the service plan. Plan reviewers review services requested for their relevance and sufficiency in meeting participant needs and risk factors, as well as the intended outcomes desired by the participant. If a plan does not meet these criteria, the reviewer returns the plan to the Service Coordinator with feedback for clarification. The Plan Reviewer will review the resubmitted and corrected plan and if the plan is still found to be lacking necessary information or services/outcomes that clearly identify addressing the identified needs and personal goals, the Plan Reviewer will contact the SC by phone to discuss the service plan and provide technical assistance to the Service coordinator in plan development. If a trend occurs with a service coordinator, the plan reviewer will contact the SC Supervisor to recommend additional training. If a trend is identified within a Service Coordination entity,

training will be provided to the agency. Further non-compliance will be referred to QMET for additional actions. Complaints regarding non-receipt of service are addressed in EIM processing, and if classified as Urgent, have a timeframe of one day for investigation initiation. See Appendix F for more information on complaint processing.

ISPs are reviewed for compliance, and any individual issues are addressed as soon as they are discovered. If issues are identified during the review, immediate remediation is undertaken. The specific problem (individual) is addressed right away through contact with the SC agency. This action will include steps needed to ensure that the individual's ISP is correctly developed, and may also include technical assistance to the provider to both address the individual issue and to prevent future issues. Immediate attention, as warranted by the circumstances, is undertaken (and overseen by OLTL through BPO in collaboration with BQPM) to ensure that individual health and welfare is assured. For all other discovered issues, the CAP process is used.

Please see Appendix H for more information on Assurance Liaisons and QIPs.

If, through tracking and trending it is discovered that a specific provider has multiple deficiencies, the Quality Management Efficiency Team (QMET) is alerted. The QMET pulls a random sample of the provider's records and reviews the ISPs to verify they meet participant needs adequately and appropriately. If the sample reveals a provider wide deficiency in developing an ISP which meets the subassurances, the provider must complete a Corrective Action Plan (CAP) within 15 business days. OLTL reviews and approves the CAP within 30 business days of submission. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP.

If the New or Annual Participant Satisfaction Survey responses indicate that waiver participants have unmet needs, the BQPM initiates further analysis comparing with other data sources and develops a Quality Improvement Plan (QIP) or System Improvement Plan (SIP) if appropriate.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Directed Opportunities Available within the OBRA Waiver:
All participants in the OBRA waiver have the right to make decisions about and self-direct their own waiver services and may choose to hire and manage staff using Employer Authority. Under Employer Authority, the participant serves as the common-law the employer and is responsible for hiring, firing, training, supervising, and scheduling their support workers. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

How Participants May Take Advantage of Self-Directed Opportunities:
Participants may choose to self-direct their services during the development of the initial Individual Service Plan (ISP), at reassessment, or at any time. The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of opportunities within the waiver. As described in Appendix E-1-e below, the Office of Long-Term Living has developed standardized educational materials and promotional materials with information about self-direction for all waiver participants. OLTL has also developed and provided regional on-site training for Service Coordinators on self-direction to ensure information is provided accurately and consistently statewide.

As stated previously, the participant may utilize a combination of any model(s) to personalize their service plan. The ISP is developed in conjunction with the Service Coordinator, as described in Appendix D, to ensure that the participant's service needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer all participants who have chosen to self-direct their services provider-managed services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their Service Coordinator. Service Coordinators must work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

Entities That Support Individuals:
Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing Employer Authority will receive support from a certified Fiscal/Employer Agent (F/EA) and Service Coordinators to assist them in their role as the common-law employer of their workers. The Fiscal/Employer Agent will:
- Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
- Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
- Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
- Establish and maintain a separate bank account for the purposes of managing participant directed funds and provide a full accounting of the use of these funds;
- Conduct criminal background checks and when applicable, child abuse clearances, on potential employees;
- Assist participants in verifying support workers citizenship or alien status;
- Distribute, collect and process support worker timesheets as verified and approved by the participant;
- Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
- Broker workers' compensation for all support workers through an appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local

laws;
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
- Assist in implementing the state's quality management strategy related to FMS;
- Establish an accessible customer service system for the participant and the Service Coordinator; and
- Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL.

In addition, individuals choosing to self-direct their services will receive assistance from their Service Coordinator to develop their Individual Service Plan (ISP). Once the ISP is developed, approved, and authorized, the participant is responsible for arranging and directing the services outlined in their plan with, as appropriate, information and support from the Service Coordinator. During the implementation and management of the ISP, the Service Coordinator will:
- Assist the participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the participant to develop an individualized back-up plan;
- Assist the participant to identify risks or potential risks and develop a plan to manage those risks;
- Monitor the provision of services to ensure the participant's health and welfare;
- Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services; and
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one)*:

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (●) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of participant direction opportunities within the waiver. The Service Coordinator documents the participant's choice of service delivery model on the ISP. Participants are also advised that they have the opportunity to change their model of service at any time throughout the year. Participants receive information about participant-direction at time of enrollment, on an annual basis and upon request.

The Office of Long-Term Living has developed consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials include a comprehensive participant reference manual which contains details about participant-direction roles, responsibilities, and informed decision-making. These materials have been distributed to the Independent Enrollment Broker as well as all Service Coordination agencies, and are available on the OLTL website. This information is widely available and shared with individuals upon entering service, at monitoring contacts and during annual ISP updates each year thereafter. This information is written at a level that is easily understood using everyday common language to ensure accessibility, and is provided in advance of the ISP meeting to ensure that individuals have sufficient time to consider their options and the responsibilities.

The F/EA, a single statewide entity providing consistent functions across the Commonwealth, is responsible for providing orientation and training to the participant prior to employing their support service worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Support Service Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- Effective practices for recruiting potential employees, hiring employees, training employees, supervising and managing employees and firing employees;
- The process for resolving issues and complaints; and
- Workers Compensation and the process for reviewing workplace safety issues.

In addition, the F/EA is responsible for providing ongoing skills training to participants and working with Service Coordinators to identify any participants who may need and/or desire additional employer skills training.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative freely chosen by an adult participant or for any individual who is unable to:

- Understand his/her own personal care needs;
- Make decisions about his/her own care;
- Manage his/her lifestyle and environment by making these choices;
- Understand or have the ability to learn how to recruit, hire, train, and supervise providers of care; or
- Understand the impact of his/her decisions and assume responsibility for the results.

The individual, a Service Coordinator, the OLTL, or the F/EA may request a personal representative be appointed, if indicated. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- A strong personal commitment to the participant;
- Assist the participant in identifying/ obtaining back up services when a support worker does not show;
- Demonstrate knowledge of the participant's preferences;
- Agree to predetermined frequency of contact with the participant as mutually determined by the participant, the personal representative and the Service Coordinator; and
- Be at least 18 years of age.

The Service Coordinator or F/EA may request a personal representative be appointed when circumstances indicate a change in the participant's ability to self-direct or when the participant demonstrates misuse of funds, consistent non-adherence to program policy or an ongoing health and welfare risk.

A representative may not be a paid attendant for the participant.
The F/EA must recognize the participant's personal representative as a decision-maker, and provide the personal representative with all of the information, training, and support it would typically provide to a participant who is self-directing. The F/EA must fully inform the personal representative of the rights and responsibilities of a representative. Once informed, the F/EA must have the representative review and sign the standard Common Law Employer Designation Form form, which must be given to the representative and maintained in the participant's file. The agreement lists the roles and responsibilities of the representative; states that the representative accepts the roles and responsibilities of this function; and states that the representative will abide by OLTL policies and procedures.

The Service Coordinator is responsible for ensuring the personal representative functions in the best interest of the participant through, at minimum, quarterly monitoring calls, by monitoring the personal representative's adherence to the Common Law Employer Designation Form, and ensuring services are being provided as outlined in the participant's ISP. When it appears the personal representative is not acting in the best interest of the participant, and there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP, the Service Coordinator must explore other alternatives, such as appointing a new personal representative or transitioning the participant to the provider managed service delivery model as described in Appendix E-1-m below. The Service Coordinator is also required to report any incidents of suspected abuse, neglect and/or exploitation as described in Appendix G.

In addition, the F/EA is required to address and report any issues identified with the representative OLTL policy on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	☑	☐
Respite	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- [ ] **Governmental entities**
- [x] **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided to participants across the Commonwealth by one qualified Fiscal Employer Agent, which was selected through a competitive procurement process (RFA).

In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

••The statewide F/EA receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. The monthly administrative fee was established through the competitive procurement process. The selected vendor must apply the monthly per participant fee consistently with each participant enrolled with the vendor.

•A one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee. The one-time start-up administrative fee is established by DPW.

The one-time per participant start-up fee and the ongoing per member per month administrative fee may not be billed simultaneously. Payment for Financial Management Services is not based on a percentage of the total dollar volume of transactions that the FMS entity processes. The percentage of FMS costs relative to the participant's service costs are independent of one another, as service costs are based upon the assessed needs of the participant.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

•• Enroll participants in FMS and apply for and receive approval from the IRS to act as a an agent on behalf of the participant;
• Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal, state, and local tax forms; the completion of timesheets; good hiring

and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
• Conduct criminal background checks, child abuse clearances when applicable, on potential employees;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
• Compute, withhold, file, deposit and track federal, state and local income taxes in compliance with all federal, state, and local requirements;
• Broker workers' compensation for all support workers through the appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
• Assist in implementing the state's quality management strategy related to FMS
• Establish an accessible customer service system for the participant and Service Coordinator.
• Assist participants in verifying support workers citizenship or alien status; and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The statewide F/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with the OLTL F/EA contract requirements. The F/EA FMS provides specific employer agent functions that support the participant with the employer-related functions.

The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents.

OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other

vendors. If the F/EA is not in compliance with contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of monthly utilization reports, quarterly and annual status reports, as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. Service Coordinators will also be required to report any issues with the statewide FMS organization's performance to OLTL.

Lastly, the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool provided by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department.

Through the established claims oversight process, OLTL will monitors claim submitted by the F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System	☐
Nursing Services	☐
Personal Assistance Services	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Counseling Services	☐
Assistive Technology	☐
Community Transition Services	☐
Nutritional Consultation	☐
Home Adaptations	☐
Residential Habilitation Services	☐
Cognitive Rehabilitation Therapy Services	☐
Non-Medical Transportation	☐
Behavior Therapy Services	☐
Speech and Language Therapy Services	☐
Supported Employment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Service Coordination	☑
Adult Daily Living	☐
Respite	☐
Prevocational Services	☐
Structured Day Habilitation Services	☐
Vehicle Modifications	☐
Occupational Therapy	☐
Community Integration	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities to provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.

The selected F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. In addition, a one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The initial start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee The monthly administrative fee was established as part of the competitive procurement process; the one-time start-up administrative fee is established by DPW.

Participants will obtain enrollment and informational materials from the selected F/EA organization under contract with OLTL. In addition, the F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- Effective practices for hiring, training, and supervising employees;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues.

In addition, individuals choosing to self-direct their services will receive assistance and support from their Service Coordinator. The Service Coordinator will:

- Provide participants with information regarding self-direction on an ongoing basis, including information about responsibilities, rights and concepts of self-direction;
- Work with the F/EA and the participant as necessary to ensure all enrollment and employment paperwork is completed and sent to the F/EA;
- Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services;
- Assist the participant to develop job descriptions for support workers to be employed by the participant. Job descriptions must be consistent with the individual service plan;
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.
- Assist the participant in communicating with the F/EA as needed;
- Support the participant in problem-solving, decision-making, and recognizing and reporting critical incidents; and
- Monitor the provision and utilization of services to ensure the participant's health and welfare.

The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected F/EA prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. OLTL will monitor the selected F/EA to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide F/EA will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These

requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. If the FMS organization is not in compliance with a contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants have the option to transition from the participant direction to the provider managed service delivery model at any point during their waiver enrollment. When a participant voluntarily chooses to terminate participant direction, they will contact their Service Coordinator who will guide them through the process of transition. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period. The change in models will be reflected on a revised ISP.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants, or personal representatives, who demonstrate the inability to self-direct their services whether due to misuse of funds, consistent non-adherence to program policy or an on-going health and welfare risk, will be required to transition to provider managed services.

Involuntary Termination from participant direction may also occur after it has been determined that there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the ISP. Involuntary termination would only occur after a thorough review of the participant's health and welfare needs as identified in the service plan.

Termination of participant direction would occur only after a team meeting with the participant, the participant's Service Coordinator, and any family, friends and advocate if requested by the participant and a review of the recommendations by the OLTL.

The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period.

The participant has the right to an Appeal and Fair Hearing and will be given this opportunity as outlined in Appendix F-1 Right to a Fair Hearing.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	700	
Year 2	560	
Year 3	400	
Year 4	210	
Year 5	210	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

To ensure all participants make an informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services. In addition, as described in Appendix C-2-b, child abuse clearances are required when a minor child resides in the participant's home. The FMS agency secures and pays for both the criminal background check and child abuse clearances.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**

- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service (s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with OLTL policies. A participant will have his or her rights to file a fair hearing request discussed at time of enrollment, annually during the ISP annual review meeting and at any time the participant requests to change services or add new services. The OLTL Participant Information Packet, containing information about appeals and fair hearings, is distributed to the participant at enrollment and during the ISP annual review meeting.

The IEE is required to provide information on due process and appeal rights to the applicant utilizing OLTL issued standard forms when the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services as an alternative to institutional care

2. The individual is denied his or her preference of waiver or nursing facility services.

The Service Coordinator is required to provide information on due process and appeal rights to the participant utilizing OLTL issued standard forms any time the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services as an alternative to institutional care

2. The individual is denied his or her preference of waiver or nursing facility services.

3. The participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).

4. The participant is denied the choice of willing and qualified Waiver provider(s).

5. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's ISP or when the participant is involuntarily terminated from participant direction.

The IEE/Service Coordinator are required to make all such notices in writing utilizing OLTL issued documents. Should the applicant/participant choose to file an appeal, they must do so with the agency that made the determination being questioned. Title 55 Pa. Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department." The agency which receives the appeal from the participant will forward it to the Department's Bureau of Hearings and Appeals for action.

It is the responsibility of the Service Coordinator/IEE to provide any assistance the participant/applicant needs to request a hearing. This may include the following:
• Clearly explaining the basis for questioned decisions or actions.
• Explaining the rights and fair hearing proceedings of the applicant or participant.
• Providing the necessary forms and explaining to the applicant or participant how to file his or her appeal and, if necessary, how to fill out the forms.
• Advising the applicant or participant that he or she may be represented by an attorney, relative, friend or other spokesman and providing information to assist the applicant or participant to locate legal services available in the county.

Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AAA participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the initial level of care determination and the individual appeals that notice through the CAO. Service Coordinators are expected to participate when the CAO sends a notice confirming the level of care redetermination and the individual appeals that notice through the CAO.

The Service Coordinator is required to provide an advance written notice of at least 10 calendar days to the participant anytime the Service Coordinator initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the Service Coordinator, shall contain a date that the appeal must be received by the Service Coordinator to have the services that are already being provided at the time of the appeal continue during the appeal process.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the Service Coordinator, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4 (a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the Service Coordinator. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant.

Fair hearing requests are collected in a statewide database and due process is monitored by OLTL.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Office of Long Term Living (OLTL) is responsible for the operation of the grievance/complaint system.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Individuals calling the OLTL HelpLine with a complaint/grievance are logged into the Enterprise Information System (EIM), a web-based database, and the information is then referred to the appropriate Bureau for resolution. Complaints are classified as Urgent if immediate action is required to assist in safeguarding the participant's health and welfare or Non-Urgent if the participant is not at risk of immediate health and jeopardy and immediate action is not required. Any complaints determined to be an incident as described in Appendix G are entered into EIM as an incident and are treated as such for purposes of investigation and follow-through.

Investigations of Urgent complaints must be initiated with one business day, while Non-Urgent complaints have a five day timeframe for complaint initiation of the investigation. Any complaint determined to be an incident as described in Appendix G will be handled in accordance with all applicable requirements. The receiving Bureau contacts the participant, their service coordinator, and/or other necessary parties in order to determine all circumstances regarding the complaint and to make a determination about an appropriate resolution. Documentation of any actions and the resolution is entered into the database by OLTL staff and the complaint is submitted through EIM for supervisory review. The reviewing supervisor can accept the resolution allowing for closure of the complaint or send it back to staff for further action. The timeframe for additional follow-up and resolution is 45 days, but additional time can be requested through EIM in accordance with OLTL requirements. OLTL is able to generate reports from EIM about the types of participant complaints received, timeliness of resolution and examines general patterns and trends for system improvement.

In addition, EIM is designed to collect complaints received from any source, such as direct phone calls, emails, and letters or faxes in order to standardize collection and processing of all complaints in one data collection system. Participants are informed verbally and in the OLTL Participant Information Packet about the OLTL Participant HelpLine at enrollment, during their annual reevaluation, and in the cover letter that accompanies the OLTL Participant Satisfaction Surveys.

Participants are advised through OLTL's standard participant information materials that OLTL's grievance/complaint system is neither a pre-requisite, nor a substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office of Long-Term Living has initiated a comprehensive incident reporting and management process. Critical events are referred to as critical incidents and defined as an event that jeopardizes the participant's health and welfare. Two OLTL offices are involved in the oversight of the Incident Management process – the Bureau of Quality and Provider Management (BQPM) and the Bureau of Participant Operations (BPO).

Definitions of the types of critical events or incidents that must be reported:
As defined in 55 Pa. Code, Chapter 52, the following are considered critical incidents:
1. Death (other than by natural causes);
2. Serious Injury - that results in emergency room visits, hospitalizations, and death;
3. Hospitalization - except in certain cases, for example hospital stays that were planned in advance*;
4. Provider and staff misconduct – deliberate, willful, unlawful, or dishonest activities;
5. Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse are, but not necessarily limited to:
• Physical abuse – defined as a physical act by an individual that may cause physical injury to a participant;
• Psychological abuse – an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
• Sexual abuse – an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
• Verbal abuse – using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant.
* Being admitted for a non-routine medical condition that was not scheduled or planned to occur is a critical incident; a routine hospital visit for lab work or routine treatment of illness of a participant is not a critical incident. A death that is suspicious or of unexplained causes is a critical incident. A death due to natural causes is not a critical incident.
6. Neglect – the failure to provide a participant the reasonable care that he, or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.
7. Exploitation – the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self, or others;
8. Restraint – Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions and procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights.
9. Service Interruption – Any event that results in the participant's inability to receive services that places his, or her health, and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization.
10. Medication errors that that result in hospitalization, an emergency room visit or other medical intervention.

Individuals/entities that are required to report critical events:
Per 55 PA Code Chapter 52 and OLTL's Critical Incident Management Bulletin, administrators and employees of waiver service providers, including Service Coordination Entities and individual providers of waiver services, are responsible for reporting critical incidents through the electronic Incident Management system, an electronic data system that collects information regarding critical incidents involving waiver participants. In addition, Direct service providers are required to notify the participant's Service Coordinator when a critical incident occurs.

In addition to reporting an incident to OLTL, in the event a direct service provider/Service Coordination Entity has reasonable suspicion that a participant over age 60 is the victim of a crime, including abuse, neglect or exploitation, or that death is suspicious, the provider must also report under the Older Adults Protective Services Act (35 P.S. §§ 10225.101 – 10225.5102 and Title 6 Pa. Code, Chapter 15) to the local OAPSA agency/the Department of Aging. In the event providers/Service Coordination Entities have reasonable suspicion that a participant between the ages of 18 to 59 is the victim of abandonment, abuse, exploitation, intimidation, neglect, serious injury or bodily injury or sexual abuse, the provider must report under the Adult Protective Services Act (Act 70 of 2010) to the Department of Human Services' APS Hotline. For both OAPSA and APS, the provider must also inform the participant's

Service Coordination Entity within 24 hours of knowledge of the incident. For both OAPSA and APS, the direct service provider/Service Coordination Entity must also immediately contact the appropriate law enforcement official to file a report when incidents involve sexual abuse, serious injury, serious bodily injury or suspicious death. These additional reporting requirements do not supplant a provider's reporting responsibilities to OLTL.

Reporting applies to:
• Critical incidents that occur during the time the provider is providing services, and
• Critical incidents that occur during the time the provider is contracted to provide services, but fails to do so, and
• Critical incidents that occur at times other than when the provider is providing, or is contracted to provide services if the administrators, or employees become aware of such incidents.

In addition to reports received from providers through the Enterprise Incident Management (EIM) system, reports are taken from participants, families or other interested parties through OLTL's toll-free Participant HelpLine. Additional information regarding the HelpLine is contained in Appendix F.

Timeframes within which critical events must be reported and the methods for reporting:
Required reporters must report critical incidents to OLTL, and Service Coordination Entities when applicable, within 48 hours of their occurrence or discovery. OLTL has initiated a mandatory electronic reporting system for reporting all critical incidents. The electronic reporting system, referred to as EIM (Enterprise Incident Management), allows Service Coordinators and Direct Service providers to submit critical incidents through a web-based application where they are accessed by OLTL staff.

Incidents reported through the OLTL Participant HelpLine are entered into EIM by OLTL staff and the incidents are handled the same way as those reported directly through the web-based application. The following information is collected for each reported incident, regardless of how it is received: reporter information, participant demographics, OLTL program information, event type/details and description of the incident.

Reporters are notified through EIM that their incident reports have been received. OLTL staff reviews the critical incidents daily to ensure for the health and welfare of participants, to check for completeness and to ensure that what has been reported is truly a critical incident. Supervisors in BPO check the EIM dashboard daily for new incidents and refer cases to their staff for follow-up and action as appropriate.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At time of enrollment, the IEB informs participants of the incident management process. This information is provided through the participant information materials developed by OLTL. These materials include how to recognize and report abuse, neglect and exploitation, as well as the prohibition on the use of restraints, seclusion and other restrictive interventions. In addition, the information includes OLTL's toll free number and the process for reporting these occurrences to either the participant's Service Coordinator or OLTL directly. The Service Coordinator is responsible for reviewing this information at least annually with the participant at time of reassessment or if there is suspicion of abuse, neglect, exploitation or abandonment.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entity (or entities) that receives reports of each type of critical event or incident.
BPO receives reports through EIM, the Participant Helpline and any other source and evaluates all critical incidents as defined in Appendix G-1-b above.

The entity that is responsible for evaluating reports and how reports are evaluated.
The Bureau of Participant Operations (BPO) is responsible for evaluating incident reports to ensure that the provider took prompt action to protect the participant's health and welfare. This may include, but is not limited to calling 911, seeking the assistance of law enforcement, arranging medical care, or referring to a victim's assistance program. . OLTL also ensures that the provider meets the additional reporting requirements of the Department of Aging's Older Adult Protective Services Act (35 P.S. §§ 10225.101 – 10225.5102 and 6 PA Code Chapter 15), the Department of Human Services' Adult Protective Services Act (Act of October 7, 2010, P.L. 484, No. 70) or and/or the Department of Health when applicable.

OLTL supervisory staff reviews each incident as documented by the reporter to ensure that the report is complete. If OLTL determines an additional objective investigation is required due to conflict of interest, an OLTL staff member is assigned to complete the investigation and develop corrective action. Once all information is gathered, an OLTL supervisor reviews the incident, works with the Service Coordinator and/or Direct Service provider to ensure the health and welfare of the participant. The incident is closed in EIM when all appropriate actions are taken according to the specifics of the incident and when the participant's health and welfare have been ensured.

The entity that is responsible for conducting investigations and how investigations are conducted.
The Service Coordinator is responsible for conducting an investigation of incidents The Service Coordination Entity has two (2) days to provide initial information to OLTL in cases involving sexual abuse, serious injury, serious bodily injury or suspicious death, and 30 days from the initial report to provide all the information regarding the incident to OLTL.

If the incident meets the standards of 35 P.S. §§ 10225.101 – 10225.5102, Title 6 Pa. Code, Chapter 15) or the Act of Oct. 7, 2010, P.L. 484, No. 70, reporting to the appropriate protective services helpline must be done within required timeframes.

Investigations that are performed by the Service Coordination Entities include:
• Onsite investigation – An onsite in-person visit is conducted for fact finding. The incident facts, sequence of events, interview of witnesses and observation of the participant and/or environment is required.
• Telephone investigation - Review of the Incident Report (IR) revealed facts are missing or additional information is required and can be obtained through conducting a telephone investigation.

No further action is required when the incident report meets all three of the following conditions:
1) The facts and sequences of events is outlined with sufficient detail; and
2) Preventative action through the service plan is implemented and documented; and
3) The participant is not placed at any additional risk.

Service Coordinators are required to:
• Take necessary actions to ensure the health and welfare of the participant
• Follow up with direct service provider to ensure all appropriate actions have been taken.
• Complete incident report and submit to OLTL via EIM within the timeframes outlined in the OLTL Incident Management Policy if not already submitted by direct service provider.
• Conduct an investigation of the incident to determine specifics of the incident which include: Fact finding, identify the sequence of events, identify potential causes, and assess service planning to determine any needed changes and documentation.
• Provide a report to OLTL within 30 business days of the occurrence. When unable to conclude initial investigation within 30 days, request an extension from OLTL through EIM.

In cases investigated under involving protective services, the Service Coordinator works with the protective service worker to ensure the health and welfare of the participant. This may involve revisions to the service plan as necessary, to meet the participants' needs and to mitigate recurrence of the incident.

In cases where regulatory compliance or failure to effectively safeguard the participant is identified in the investigation, OLTL will conduct an on-site review of the Service Coordination Entity or direct service provider to audit agency procedures and make corrective recommendations resulting in a Statement of Findings.

The timeframes for conducting an investigation and completing an investigation.
The investigation of all critical incidents must be completed within 30 days of receiving the incident report. If the timeframe is not met the details regarding the delay will be documented in EIM. OLTL reviews and approves extension requests and closely monitors any investigative process that is taking beyond the allotted time for completion.

Within 48 hours of the conclusion of the critical incident investigation, participants must be informed of the outcome of investigations. The Service Coordinator is responsible for conveying this information to the participant.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OLTL is responsible for providing oversight of Critical Incidents and events. OLTL staff from BQPM and BPO work together to address critical incidents. BQPM staff reviews reports generated in EIM to track and trend critical incidents. BPO staff work with Service Coordinators and Direct Service providers to assure that participant health and welfare is protected. Together, these two bureaus discuss trends to identify systemic weaknesses or problems with individual providers.

The findings and quality improvement recommendations are shared with OLTL's Executive and Management staff at the monthly Quality Management Meetings (QM2) and the Quality Council Meetings, which are held three times a year. The QM2 and Quality Council make recommendations to the Director of the BQPM who presents them to the OLTL Deputy Secretary.

Additional Agencies responsible for oversight include the Department of Aging, DHS' Adult Protective Services office and the Department of Health. The Department of Health has licensure requirements regarding reporting of incidents and conduct annual licensure of all Home Health and Home Care entities.

The Department of Aging maintains a statewide database on all participants who were referred to the Protective Service Unit for investigation of allegations of abuse, neglect, exploitation and abandonment and oversees the Older Adult Protective Services program. . The Department of Human Services has procured an Adult Protect Services vendor that is responsible for receiving and

investigating reports of suspected abuse, neglect, abandonment and exploitation for adults with disabilities between the ages of 18 and 59. The Adult Protective Services Program was active April 1, 2015.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

At time of enrollment, the IEB informs participants of the prohibition on the use of restraints, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of restraints with the participant. As part of the participant informational materials, participants are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of restraints.

The Office of Long Term Living is notified about unauthorized use of restraints through the Service Coordination Entities and participants. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the unauthorized use of restraints, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of restraints. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

Title 55 PA. Code Chapter 52 prohibits the restraint of a participant. Sanctions are available to the OLTL for non-compliance.

This requirement is monitored during onsite provider monitoring activities by the Quality Management Efficiency Teams.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of restrictive interventions with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of restrictive interventions.

The Office of Long-Term Living is notified about unauthorized use of restrictive interventions through the Service Coordination Entities and participants. Once a complaint has been filed, it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of restrictive interventions, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of restrictive interventions. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

Title 55 PA. Code Chapter 52 prohibits the restraint of a participant. Sanctions are available to the OLTL for non-compliance.

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

At time of enrollment, the IEB informs participants of the prohibition on the use of restraint, seclusion and other forms of restrictive interventions. This information is provided through the participant information materials developed by OLTL. The Service Coordinator is responsible for reviewing this information at least annually at time of reassessment and discussing the prohibition of seclusion with the participant. As part of the participant informational materials, participants and their families are encouraged to either call their Service Coordinator or the OLTL Participant HelpLine to report the unauthorized use of seclusion.

The Office of Long-Term Living is notified about unauthorized use of seclusion through the Service Coordination Entities and participants. Once a complaint has been filed, it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of seclusion, OLTL requires all Service Coordination providers to provide annual staff training on detection and prevention of abuse and neglect including the use of seclusion. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

OLTL Bureau of Quality & Provider Management (BQPM) is responsible for monitoring and oversight of the use of restrictive interventions during onsite provider monitoring conducted every 2 years.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Healthcare practitioners are the primary entity that has ongoing responsibility for monitoring participant medication regimens. As the professionals who prescribe the medications, they ensure that the medication regimen meets the participant's diagnosed condition, that none of the medications conflict and that the doses are prescribed correctly.

Medication monitoring also occurs through the development of the participant's ISP and Service Coordinator review of the participant's services and during each face-to-face monitoring visit. As outlined in C-3, Service Coordination Entities must have Registered Nurse (RN) consulting services available, either through a staffing arrangement or through a contracted consulting agency. RNs may provide assistance in reviewing medication regimens for individuals during face-to-face monitoring visits. Service Coordinators can also use the OLTL regional team staff for support with regard to questions about medications. Regional teams have access to nurses and the OLTL Medical Director to help with questions about medications. Service Coordinators also review medication regimes for individuals during face-to-face monitoring visits and review EIM for reported medication errors. Incidents are reviewed by BPO which follows up with Service Coordinators to advise appropriate action.

Second-line monitoring is completed by Service Coordinators as outlined above and verified by the Department of Human Services, Bureau of Human Services Licensing (BHSL) annually for participants who live in licensed residential habilitation settings. Medication s in licensed settings is governed under the following authority: 55 PA Code, Chapter 2600, §2600.181 through §2600.191. Additionally, the OLTL QMETs review both licensed and unlicensed settings on a biennial basis to ensure that medication is administered per OLTL policy and that any errors were reported to the licensing entity and OLTL as an incident. Monitoring authority for the requirements enumerated in this bulletin is provided by 55 Pa. Code § 52.22 (4) (relating to provider monitoring). Providers shall produce documentation on medication management and administration as requested by the Department

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

OLTL uses the DHS Medication Administration Program to teach unlicensed staff to give medication to participants using a standard curriculum. Many of the provider agencies have nurses who become trainers and monitor medication through the course, while others provide oversight within the agency for medication administration and health issues. The course requires periodic reviews of staff performance to maintain certification. These include reviews of Medication Administration Records or logs for each staff member administering medications. The review of medication administration logs for errors in documentation includes matching the participant's prescribed medications on the log to those available to be given. Maintenance of certification requires review of four (4) Medication Administration Records and two (2) observations of passing medication and documentation. Providers are to use Medication Administration Records from different participants when completing the reviews so that each of the participants' medication regimens are reviewed across the year. As well the course also teaches staff to review medication when it is received from the pharmacy and compare it to the Medication

Administration Records, thus providing a regular review of medications by provider staff. Part of the documentation and checks include looking at medication allergies for the possibility of a contraindicated drug.
Providers administering medications are required to have a Medication Protocol in place that details the staff that have been trained and/or are licensed to administer medication, and ensures that providers have trained or licensed staff is on duty when individuals need medication administered. The Medication Management Protocol will also detail how the provider monitors medication administration on a daily basis.

Despite the Department's extensive medications administration course, medication errors do sometimes occur. Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as outlined in Appendix G-1-b. If the medication error is the result of a critical incident, such as neglect, or results in a critical incident, such as death, then it is not reported as a medication error, but rather as the higher level critical incident, which is then subject to Service Coordinator investigation and review.

Documentation of medication errors and the prescriber's response must be kept in the participant's record. Providers are required to have a system in place to identify and document medication errors and the pattern of error. Providers must also document follow-up actions that have been taken to prevent future medication errors. Finally, providers are also required to educate participants of their right to question or refuse medication if the participant believes there may be a medication error. Documentation of this individual education must be kept in the participant's file.

If a participant experiences a suspected adverse reaction to a medication, the provider is required to immediately consult a physician or seek emergency medical treatment. Adverse reactions, the prescriber's response and any actions taken are documented in the participant's record.

The Department of Human Services, Bureau of Human Services Licensing (BHSL), monitors licensed Residential Habilitation providers compliance with 55 PA Code, Chapter 2600, §2600.181 through §2600.191on an annual basis, and is responsible for oversight and follow-up when licensed providers exhibit noncompliance.

OLTL monitors unlicensed Residential Habilitation provider's recorded and reportable medication errors to determine what medication administration and management problems are occurring for Residential Habilitation Service providers. Providers who have a high number of medication errors will be retrained and medication administration will be included in the QMET's statement of findings OLTL will issue a Statement of Findings to those providers who have a high number of medication errors. The provider will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration by Licensed Residential Habilitation Providers:
Personal Care Home regulations, 55 PA Code, Chapter 2600, apply when participants receive Residential Habilitation Services in licensed settings. These regulations allow for the administration of medication by unlicensed staff when trained using the DHS-approved medications administration course. The current medications administration course requires the review of medication administration logs for errors in documentation including matching the person's prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff is not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self-administration guidelines also appear in the regulations, and setting up and monitoring self-administration programs are taught as part of the medication administration program. Personal Care Homes are licensed by the DHS, Bureau of Human Services Licensing, on an annual basis. These requirements do not apply to non-licensed providers.

Medication Administration by Unlicensed Residential Habilitation Providers:

Unlicensed Residential Habilitation providers are required to follow- OLTL's "Medication Management Policy for Unlicensed Providers Bulletin", which clarifies when a participant is expected to self-administer, receive assistance with medication administration, and the training required for provider staff to administer medication.

Self-Administration.
(a) A provider shall assist individuals, as needed, with medication prescribed for the individual's self-administration. This assistance includes helping the individual to remember the schedule for taking the medication, storing the medication in a secure place and offering the individual the medication at the prescribed times.

(b) If assistance includes helping the individual to remember the schedule for taking the medication, the individual shall be reminded of the prescribed schedule.

(c) The individual's service plan shall identify if the individual is able to self-administer medications. An individual who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

(d) If the individual does not need assistance with medication, medication may be stored in an individual's room for self-administration. Medications stored in the individual's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

(e) To be considered capable to self-administer medications, an individual shall:

(1) Be able to recognize and distinguish his medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(f) The individual's record kept by the provider shall include a current list of prescriptions, Complementary and Alternative Medications (CAM) and Over the Counter (OTC) medications for each individual who is self-administering medication.

Medication Administration:
(a) A provider may provide medication administration services for an individual who is assessed to need medication administration services and for an individual who chooses not to self-administer medications in accordance with an assessment done by a physician and documented on the individual's service plan.

(b) Prescription medication that is not self-administered shall be administered by one of the following:

(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the setting in which the medication is administered.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the setting the medication is administered.

(4) A staff person who has completed the DHS-approved medication administration training for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Medication Administration Training
(a) Pursuant to 55 Pa. Code § 52.14(t) (relating to ongoing responsibilities of providers), providers are required to participate in Department-mandated trainings. A provider who chooses to provide medication administration services for an individual who is assessed to need medication administration services in accordance with an assessment referenced above must participate in an OLTL-approved medications administration course.

(b) For the purposes of this bulletin, an OLTL-approved medications administration course refers to the Department of Human Services Office of Developmental Program's training program. Information on this training program is found by calling 1-800-438-1958 or by going to: http://www.dhs.state.pa.us/provider/training/medicationadministration/index.htm

(c) A staff person who has successfully completed the Office of Long-Term Living (OLTL)-approved medications administration course that includes the passing of the OLTL-approved performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

(d) A staff person is permitted to administer insulin injections following successful completion of an OLTL-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of an OLTL-approved diabetes patient education program within the past 12 months.

(e) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin. EIM is accessible to the state, Service Coordinators and providers.

(b) Specify the types of medication errors that providers are required to *record:*

Providers record medication errors which include: failure to administer a medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer a medication at the prescribed time, administration to the wrong person, and administration through the wrong route.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to OLTL via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

OLTL monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3-b-i, direct monitoring occurs through annual DHS licensing reviews of licensed Residential Habilitation providers and QMET biennial monitoring reviews of unlicensed Residential Habilitation providers. In addition, direct monitoring occurs as part of the Service Coordinator's face-to-face monitoring visits with participants.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-1: Number and percent of unexplained or suspicious deaths for which review/investigation occurred Numerator: Unexplained or suspicious deaths for which review/investigation resulted in findings where appropriate follow-up or steps were taken Denominator: Total number of unexplained deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
HW-2: Number and percent of substantiated cases of abuse, neglect, or exploitation where recommended actions in the protect health and welfare were implemented Numerator: Number of substantiated cases of Abuse, ,neglect, or exploitation where recommended actions to protect health and welfare were implemented Denominator: Total number of substantiated cases of abuse, neglect, or exploitation

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-3: Number and percent of Urgent complaints with investigation initiated within the required timeframe Numerator: Number and percent of urgent complaints with investigation initiated within the required timeframe Denominator: Total number of urgent complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Performance Measure:
HW-4: Number and percent of Non-Urgent complaints with investigation initiated within the required timeframe Numerator: Number of non-urgent complaints with investigation initiated within the required timeframe Denominator: Total number of non-urgent complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-5: Number and percent of complaints, investigated/closed within required timeframe
Numerator: Number of complaints, investigated/closed within required timeframe
Denominator: Total number of complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-6: Number and percent of waiver participants, responding to the satisfaction survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Numerator: Number and of waiver participants, responding to the satisfaction survey, who indicate knowledge of how to report abuse, neglect or exploitation (ANE) Denominator: Total number of participants responding to the survey

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-7: Number and percent of waiver participants who were informed of the reporting process for abuse, neglect and exploitation Numerator: Number of waiver participants who were informed of the reporting process for abuse, neglect, and exploitation Denominator: Total number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Retrospective service plan review

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-8: Number and percent of waiver participants with more than three reported incidents within the past 365 calendar days Numerator: Number and percent of waiver participants with four or more reported incidents within the past 365 calendar days Denominator: Number of waiver participants with reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-9: Number and percent of critical incidents reported within the required timeframe Numerator: Number of critical incidents reported within the required timeframe Denominator: Number of critical incidents reported

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-10: Number and percent of reportable incidents investigated within required timeframe
Numerator: Number of reportable critical incidents investigated within required timeframe
Denominator: Total number of reportable critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-11: Number and percent of critical incidents requiring investigation where the state adhered to the follow-up methods as specified in the approved waiver Numerator: Number of critical incidents requiring investigation where the state adhered to the follow-up methods as specified in the approved waiver Denominator: Total number of critical incidents requiring investigation

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW 12: Number and percent of participants who reported incidents in which they were provided guidance materials informing them of strategies to mitigate and prevent critical incidents after conclusion of investigations Numerator: Total number of participants who reported incidents in which they were provided guidance materials Denominator: Total number of reported incidents

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-13: Number and percent of incidents where unauthorized uses of restrictive interventions were appropriately reported Numerator: Number of incidents where unauthorized uses of restrictive interventions were appropriately reported Denominator: Total number of incidents with unauthorized uses of restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
EIM system

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-14: Number and percent of waiver participants receiving age-appropriate preventative health care Numerator: Number of waiver participants receiving age-appropriate preventative health care Denominator: Total number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
PROMISe paid claims report, participant enrollment file

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: PROMISe paid claims report to enrolled waiver participant report	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Statistical reports on 100% of reported critical incidents and complaints are generated from the state's Enterprise Incident Management (EIM) system and these reports are reviewed monthly by the Bureau of Quality & Provider Management (BQPM) HW Assurance Liaison for patterns in the types of incidents and complaints received. The Liaison is also looking for patterns and issues regarding how the incidents and complaints are processed, i.e. was the reporting timeframe met, etc., according to the elements of the performance measures.

The HW Assurance Liaison reviews data from the OLTL participant satisfaction surveys for question # 16 pertaining to participants who indicate knowledge of how to report abuse, neglect and exploitation. One hundred percent of returned surveys responses are monitored and aggregated three times a year.

Please see Appendix H for more information regarding the Assurance Liaison's role in the Quality Improvement Strategy.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When it is discovered that an incident was not acted upon in accordance with waiver standards (not reported, not investigated within the required timeframe, etc.) OLTL staff that discovered the issues immediately directs the provider to report the incident utilizing OTLT Incident reporting protocols, investigate, make corrections and/or otherwise meet OLTL incident standards. If immediate action is required to protect the Health and Welfare of the individual the provider is instructed to take such action, The Bureau of Participation Operations may be required to investigate and/or take action if the provider is identified as a source of the incident. When a pattern of not reporting is determined a referral is made to the Quality Management Efficiency Team (QMET) for review of the providers' incident protocols and implementation. As issues are

discovered, Corrective Action Plans (CAPs) are required of the providers.

Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G. When it is discovered that a participant has more than three reportable incidents within the past 365 days, the Health & Welfare (HW) Liaison reviews and analyzes the incidents to determine the effect on the participant. If the pattern of incidents has an effect on the health and welfare of the participant, the HW Liaison issues a QIP (see Appendix H) for immediate intervention. The QIP, with the Bureau of Participant Operations (BPO) recommendations or action plan, is returned to the BQPM within 15 business days. The BQPM reviews and approves the QIP, notifying BPO of approval and initiating the follow-up process (QIP Protocol).

The BQPM reviews for patterns involving providers, geographic areas, etc. If specific provider(s) are involved in a pattern of frequent incidents, a referral is made to the Quality Management Efficiency Team (QMET) for a targeted review and possible Corrective Action Plan (CAP). The BQPM also refers these participants to BPO through the Quality Improvement Plan process (QIP) under the standard of ensuring health and welfare. Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G.

If the BQPM discovers that a complaint was not acted upon in accordance with waiver standards, the BQPM issues a Statement of Finding and requests a QIP from the BPO.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Bureau of Quality and Provider Management (BQPM) in the Office of Long Term Living (OLTL) is responsible for developing and maintaining the Quality Improvement Strategy (QIS).

The OLTL developed a QIS for Home and Community Based Services (HCBS) Waivers to measure performance regarding service provision and to ensure the health and safety of participants. The QIS uses the quality management functions of discovery; remediation and improvement to identify and recommend systems improvements.

The Division of Quality Assurance in BQPM is responsible for collecting discovery and remediation information, analyzing that information, recommending system improvements and analyzing the effectiveness of the improvement initiatives. This Division is comprised of the Quality Management Unit (QMU) and the Quality Management and Efficiency Teams (QMET).

The functions of the Division of Quality Assurance are:
• To conduct quality monitoring of long term living programs and services to ensure compliance with federal and state regulations and the 6 waiver assurances
• To conduct provider monitoring to align with the 6 assurances to gather accurate data to determine compliance
• To compile reports for on data for the 6 assurances to measure the effectives of program design and suggest improvement initiatives
• To use data to support the development and implementation of policies and protocols to insure quality program outcomes
• To develop and implement training and technical assistance for staff, providers and participants to insure quality service delivery
• To convene a Technical Assistance Workgroup comprised of OLTL staff to insure consistent policy communication to

providers and staff
• To collaborate with other bureaus in the OLTL, external stakeholders, other state agencies and the Quality Council to effectively implement this QIS
• To recommend strategies for continuous quality improvement
• To maximize the quality of life, functional independence, health and welfare and satisfaction of participants in OLTL waivers

The following reports are used to collect data which is then analyzed by the QMU to implement the QIS. The frequency of data compilation is indicated after each report. Each of the reports listed below was specifically designed to collect the data needed to assure compliance. The QMU works with various other bureaus and divisions in the OLTL to ensure the reports and data collected are valid and being set up and compiled correctly. The reports are monitored to determine possible causes of aberrant data and compliance issues.

Administrative Authority Assurance:
• Level of Care Determination Report - Quarterly
• Independent Enrollment Broker Contractual Obligation Report for Area Agencies on Aging - Quarterly
• Initial and Annual Level of Care Report - Quarterly

Qualified Provider Assurance:
• Qualified Provider Report - Quarterly
• Initial Provider Enrollment Report - Quarterly

Service Plan Assurance:
• Service Plan Assurance Data Report - Monthly
• Participant Satisfaction Survey Results – 3 times per year
• QMET Report on Service Delivery - Quarterly
• Enterprise Incident Management (EIM) Report on Complaints - Monthly/On Demand

Health and Welfare Assurance:
• Three EIM Reports on Complaints and Incidents – Monthly/On Demand
• Participant Satisfaction Survey Reports – 3 times per year

Financial Accountability Assurance
• Onsite Paid Claims Report - Quarterly
• PROMISe Paid Claims Report - Monthly
• FEA Deliverable Report - Monthly

The reports obtained are reviewed by Quality Management Liaisons (QML) in the QMU. Data is analyzed and reviewed for each assurance. When areas of low compliance are identified, strategies to mitigate the non-compliance are discussed first with the Unit Supervisor, then Division Director and subsequently at the Quality Management Meeting with representatives from each bureau in OLTL in attendance. At that meeting, each member of the group suggests and discusses ideas to increase compliance with the particular assurance previously identified as problematic. An agreement is reached on a plan to roll out to involved entities, such as providers or contracted entities. The bureau responsible for the entity is directed to implement the plan and follow up for technical assistance. Compliance with the assurance is then monitored closely to insure the compliance rate increases. If this is not the case, the process begins again until the compliance rate increases to the acceptable level.

Quality information is reported to agencies, waiver providers, participants, families and other interested parties in several ways. The OLTL distributes information internally during monthly Quality Management Meeting. These meetings are comprised of OLTL Bureau Directors and/or designees as well as other OLTL staff who may be invited. Information related to the performance measures is shared and if needed remediation is discussed for achieving targeted goals. After discussion, at the Quality Management Meeting. Quality information is also presented at the Department of Human Services (DHS) Medical Assistance Advisory Committee Meetings as requested. These meetings involve DHS and stakeholders. The OLTL also provides data as requested to providers, participants and other parties. Results from the Participant Satisfaction Survey are posted on the DHS website 3 times per year. Results from provider monitoring are communicated to providers as soon as possible after the monitoring takes place.

Summarized below are the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each assurance.
1. The QML for each of the assurances reviews the data collected to determine compliance issues.
2. The data collected is aggregated for tracking and trending.
3. The QML makes initial recommendations and prioritizes issues for problem solving and corrective measures to the Unit Supervisor.
4. The Unit Supervisor reviews the recommendations and presents the issue to the Division Director.
5. Issues are then placed on the agenda for the Quality Management Meeting.
6. At the Quality Management Meeting, issues and data are presented to the members.
7. Recommendations are made to remediate the issue.

8. The Director of the BQPM makes the decision on which plan will be used to remediate.
9. The appropriate bureau implements the plan with the responsible entity and provides technical assistance to implement the plan.
10. The QML insures that the plan was successful by reviewing the compliance data following implementation of the plan.
11. The QML reports on the success of prior remediation activities at Quality Management Meetings.

This above process outlines the OLTL QIS. The QIS is reviewed at each Quality Management meeting (monthly) to insure the QIS is working and on target.

The roles and responsibilities are as follows:

Quality Management Liaisons:
• Identify and collect needed data
• Ensure that data from reports is valid and accurate captures compliance with the 6 assurances
• Aggregate, review and analyze data to identify issues and trends
• Identify compliance issues
• Look for aberrant data and determine causes
• Make initial recommendations for problem solving, corrective measures and system changes
• Follow up on effectiveness of remediation plan and recommend alternatives if plan is not achieving desired result of reducing non-compliance
• Develop mandatory training for Service Coordinators on Assurances

Unit Supervisor and Division Director:
• Review QML issues and recommendations for inclusion in the monthly Quality Management meetings.
• Maintain an Issues Chart to track progress on remediation and system changes and insure the issue is resolved and non-compliance is reduced.
• Hold monthly Quality Management meetings with OLTL Bureau Directors to discuss trends and plans to correct quality issues.

Representatives from OLTL Bureaus:
• Attend meetings
• Make recommendations and suggestions to remediate issues and system changes
• Review recommendations made by QML
• Monitor follow up and results

BQPM Director
• The Director of BQPM oversees the daily progress of activities related to the performance measures outlined in the waiver. The Director also reviews and has input on the identification and collection of all data to be used in reports during the monthly Quality management Meetings and also what may be shared with the Medical Assistance Advisory Committee. The Director will also make final decisions on plans to be followed to remediate identified issues.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The process to continuously assess the effectiveness of this QIS and revise as necessary is as follows:
• Monthly Quality Management Meeting will be held with the sole purpose of looking at the QIS and evaluating the effectiveness of the strategy.
• Prior to submission of the Evidentiary Based Review for the waiver renewal, a Quality Management Meeting will be held for the same purpose.
• Independent persons not associated with OLTL will be invited to access the effectiveness of the strategy.
• The Issues Chart will be made available along with a summary of the steps taken to resolve the issues.
• The Independent Reviewer will access and make recommendations for change.
• Annually a Quality Management Meeting will be dedicated for review of the Issues Chart and recommendations for change.

The Quality Improvement System outlined also applies to the Aging (control number 0279), Attendant Care (control number 0277), Independence (control number 0319), CommCare (control number 0386). The discovery and remediation data gathered during the implementation of the QIS will be waiver specific and stratified. Because the renewals are staggered, the QIS will automatically receive a periodic evaluation during the point of the renewal of each waiver. The QIS process for the OBRA waiver will be reviewed after the EBR final report and prior to the submission of the renewal.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy (QIS) will be evaluated on an on-going and continuous basis through the implementation of the continuous quality cycle. QIS changes will be collected and reported on the annual CMS 372s. The QIS will require a formal review every two years. For the two year review, the Quality Management Unit (QMU) Assurance Liaisons will follow the QMU QIS Evaluation Protocol, will review the waiver assurance's discovery and remediation functions, and will apply comments and recommendations. In addition the QIS Liaison will review the Improvement Strategy, collect input from OLTL and will combine the resulting recommendations with those that are reported on the waiver assurances. Additional input from the OLTL Quality Meetings will be considered and follow-up on identified issues will occur through the QIS. The results of aggregated information pertaining to the delivery of services including all corrective action plan activities of providers, provider billing information, analysis of provider adherence to performance measures established, etc. will be reviewed and discussed to evaluate the effectiveness of program success. Any needed alterations to the QIS will be made after this evaluation is completed.• The Cognos report's data is manually verified.
• The size of the data sample is supported through the use of a sample size calculator available at: https://content.metrixmatrix.com/sample.html.
• The report's data is randomly sorted through Microsoft Excel Macros.
• The random data sample that is created by the Microsoft Excel Macros is used to identify the HCBS claims that are to be reviewed for a HCBS provider.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following are the audit and financial review requirements to ensure the financial integrity of the waiver program as specified in PA Code §52.43 Audit Requirements:

1. Providers shall comply with the Federal audit requirements as specified in Section 74.26 of 45 CFR (relating to non-Federal audits).

2. Providers who meet certain thresholds as specified in OMB Circular A-133, as revised, and the Department of Human Services' (DHS) Annual Single Audit Supplemental Publication are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502, as amended, and to complete DHS's annual Single Audit Supplement publication.

3. Providers who are not required to comply with the Singe Audit Act of 1984 during any program year shall maintain auditable records in compliance with PA Code §52.43.

4. DHS may request that a provider have the provider's auditor perform an attestation engagement; DHS or DHS' designee may perform an attestation engagement; or DHS may request that the provider's auditor conduct a performance audit in accordance with the following:
a) Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards (GAGAS).
b) Standards issued by the Auditing Standards Board.
c) Standards issued by the American Institute of Certified Public Accountants.
d) Standards issued by the International Auditing and Assurance Standards Board.
e) Standards issued by the Public Company Accounting Oversight Board.

f) Standards of successor organizations to those organizations in paragraphs a. through e. above.

Providers are required to follow the provisions of 55 PA Code Chapter 52.43(n), which states that "a provider shall retain records that relate to litigation of the settlement of claims arising out of performance or expenditures under a waiver or the Act 150 program to which an auditor has taken exception, until the litigation, claim or exceptions have reached final disposition or for a period of at least 5 years from the provider's fiscal year-end, whichever is greater." See 55 PA Code Chapter §52.43 at the following link: http://www.pacode.com/secure/data/055/chapter52/055_0052.pdf

If the provider has a settlement of claims as a result of litigation, then the provider must retain auditable records 5 years from the end date of the litigation or 5 years from the provider's fiscal year-end, whichever is greater. Additionally, the provider must retain records beyond the 5 year period if DHS or another State or Federal agency has unresolved questions regarding costs or activities of the provider.

Payments to providers are also controlled by edits built into the Commonwealth's MMIS system known as PROMISe™. Claims for services are matched against the eligibility system (CIS) so that payments are not made for recipients that have not been approved for Medicaid and for the waiver. Additionally, the PROMISe™ system will not pay claims if a participant does not have either the service or the provider included in the approved service plan for the recipient in the HCSIS system.

The Office of Long-Term Living's (OLTL), Quality Management Efficiency Teams (QMET) conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). The ISPs are developed by service coordination entities along with participant input and based upon an assessment of the participants needs. Monitoring of the financial records provides the opportunity to reevaluate the ISPs by looking at utilization of services to identify trends such as underutilizing services and overutilization.

In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type i.e.: personal assistance service, RN Services, etc.

At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.

OLTL does not review in detail any internal controls, ledgers, costs, or budgeting documentation at the agencies. OLTL does not reimburse providers based upon costs or conduct cost settlements for its HCBS waiver services; services are reimbursed based upon the established MA fee schedule.

The HCBS Field Operations Manager is responsible to direct five (5) regional teams which monitor and report data on provider compliance. These regional teams are collectively called QMET. The majority of QMET is comprised of contract staff. The regional teams include financial representatives that are responsible in conjunction with other team members to perform monitoring reviews.

Responsibilities of the financial representative include, but not limited to, assessing whether or not the provider entity has maintained sound fiscal practices, billed DHS properly, and used DHS funds in accordance with program guidelines, determine the appropriateness of costs claimed for DHS subsidy, determine whether an entity is managing and utilizing its resources economically and effectively and identify the causes of inefficient or uneconomical practices.

Depending on the findings of the QMET reviews, remediation may include:
• Suspending claims pending review prior to payment.
• Review of provider's records.
• Review of provider's written billing policies/procedures.
• Sanctions, prohibition or disenrollment from providing services.
• Prohibition from serving new participants.

When overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken by the Division of Provider and Operations Management. Providers will receive a series of letters outlining what steps they must take, within a specified time frame, to correct the overpayment. The first letter outlines the overpayments that have been identified and allows the agency to submit further supporting documentation to validate the payment received. The provider is given a 15 day window to comply with this request. If the provider cannot or does not respond, a second letter outlines that they have an additional 15 days to comply or the Department will begin to recover the identified overpayments through either adjustments to future claim payments or a

lump sum payback. If OLTL receives no response or the provider agrees with the overpayment, the Department discusses payment methods with the agency and either allows a one-time payment via check, a monthly payback via check, or reduces future payments to that agency until the full amount of the overpayment is recovered.

Regulation § 52.43(e) states that the Department may request a performance audit to be performed by the provider's financial professional in accordance with any of the standards listed in 55 Pa. Code § 52.43(c).

In order to assure that each claim is processed in accordance with the approved waiver OLTL-specific edits and audits were developed and are maintained for the State's CMS certified Medicaid Management Information System (MMIS). PROMISe™ is the MMIS utilized for claims processing. Claims that are incomplete or contain invalid Information are denied to ensure compliance with what is specified in the approved waiver.

A provider which is not required to meet the threshold for an annual audit will maintain auditable records. The provider will maintain books, records and documents that support the type, scope, amount, duration and frequency of service provision.

Providers are subject to on-site reviews every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Review of the provider's cost accounting systems is minimal. QMET gathers, from the provider, an independent audit (if completed) and financial documentation such as balance sheets, tax returns and bank statements. QMET does not perform any formal testing/review of these documents. These documents are viewed onsite by the Financial Representative(s), and if there are any unusual items or obvious cash flow and/or going concern issues, QMET it to make note. QMET does not review in detail any internal controls, ledgers, costs, or budgeting documentation at the agencies.

Providers may also be selected for a GAGAS performance audit by the DHS Bureau of Financial Operations.

All allegations of suspected fraud and financial abuse are directed to the Bureau of Program Integrity (BPI) within the Department of Human Services. Instances are reported by calls, letters and emails from providers, participants, care workers, witnesses etc. In addition to reports that are received directly to BPI, QMET staff may discover potential instances of fraud and abuse during the course of on-site monitoring. Pertinent information is compiled by QMET and forwarded on to BPI for investigation.

Please note, OLTL does not license or prior authorize services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

      Performance Measures

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

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

      Performance Measure:
      FA-1: Number and percent of claims paid within in accordance with approved waiver
      Numerator: Number of claims paid within in accordance with approved waiver Denominator:
      Total number of claims paid

Data Source (Select one):
Other
If 'Other' is selected, specify:
Paid Claims Report

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

Data Aggregation and Analysis:

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

Performance Measure:
FA-2: Number and percent of provider's submitting accurate claims for services authorized by the waiver and being paid for those services Numerator: Total number of providers submitting accurate claims for services authorized Denominator: Total number of providers reviewed

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Ongoing reviews in a two year period to reach each provider with a 95% confidence level +-5%	

Data Aggregation and Analysis:

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

Performance Measure:
FA 3: Number and percent of claims that are paid based on the correct rate Numerator: Number of claims that paid at the correct rate. Denominator: Total number of paid claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
PROMISe

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

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

Data Aggregation and Analysis:

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

Performance Measure:
FA 4: Number and percent of claims paid timely Numerator: Number of claims paid timely Denominator: Total number of paid claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
PROMISe

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
FA-5: Number and percent of provider payment rates that are consistent with rate methodology approved in the approved waiver application or subsequent amendment Numerator: Number and percent of provider payments rates are consistent with rate methodology approved in the approved waiver application or subsequent amendmen Denominator: Total number of provider payments using the appropriate rate

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data, documentation from State rate setting division

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
A "Paid Claims Report" has been developed that runs every paid claim against a valid list of procedure codes. 100% of all paid claims are run through the query which is written to list any claims that paid with an incorrect code. If any claims would pay and not be valid, the circumstances of each claim would be investigated

FA-1: The QMU Liaison reviews the report that has been run. If no claims are listed on the report, all of the paid claims paid

using correct procedure codes that are valid under the waiver.
FA-2: The QMU Liaison reviews the data that has been reported by the QMET teams. The data is tracked and trended against prior reporting periods to draw conclusions relating to levels of compliance.
FA-3: The QMU Liaison reviews the report that has been run. Any claims that do not pay at the correct rate will not meet the Assurance. These claims would be reprocessed at the correct rate.
FA-4: The QMU Liaison reviews the report that has been run. Any claims that do not pay timely will not meet the Assurance. Only timely claims should be paid.
FA-5: The QMU Liaison reviews the report that has been run. The rate file is delivered to OLTL electronically. OLTL reviews the file for errors. DHS Bureau of Data and Claims Management does testing after rates are loaded into PROMISe to ensure the rates are loaded correctly. The rates are reviewed each time any changes are made to the PROMISe rate tables.

Universe. FA-1: Numerator: Total number of claims that paid using correct procedure codes. SFY 2013-14 – 881,396 claims. Denominator: Total number of paid claims. SFY 2013-14 – 881,396 claims.
FA-2. 766 total providers. Numerator: number of providers reviewed that paid correctly. Denominator: number of providers reviewed during each quarter.
FA-4. 140 payment rates.
FA-1: Paid Claims Report is analyzed. Based on results, further investigation of the paid claims and processing system may be needed.
FA-2: Based on the results from QMET on site findings, providers will make necessary changes through the Corrective Action Plan remediation process. OLTL is exploring the option of collection this data systemically instead of onsite reviews.
FA-5: Rates will not become official without passing the PA review process that they were done using the correct methodology.
If a claim passed all of the edit and audit checks in the PA PROMISe claims processing system, they have been coded and paid for in accordance with the reimbursement methodology.
QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc.

At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.

Pennsylvania contracted with a vendor to assist with setting the payment rates. Parameters were agreed upon that would be critical to achieving the rate setting methodology. The rates went through a comment and vetting process. These accepted approved rates are loaded into the PA PROMISe payment processing system, that the claims pay against, only after CMS approval of OLTL's rate methodology. An outside vendor under the direction of the Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) Bureau of Data and Claims Management (BDCM) run the rates and claims in a test environment to be certain that they are working correctly before they are loaded into the live PROMISe environment for claims processing.

The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. Using a standard monitoring tool which incorporates the Financial Accountability requirements as listed in the waiver, the QMET verifies each requirement during the review. The QMET review includes verifying claims submitted in PROMISe with service plans. A random sample of provider, employee, and consumer financial records are reviewed to ensure compliance with waiver standards.
Claims data is examined against a sample of HCSIS files to determine if paying properly based on plan authorizations

The State uses the following website to determine sample sizes: http://www.raosoft.com/samplesize.html

b. Methods for Remediation/Fixing Individual Problems

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

If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/Bureau of Quality & Provider Management initiates steps to recoup the overpayment.
The following language was added based on CMS RAI questions: If the provider and OLTL cannot come to a mutual agreement regarding the recoupment of an overpayment, the provider may request an appeal in writing with the DHS Bureau of Hearing and Appeals (BHA). After hearing testimony from both OLTL and the provider, the Hearing Officer would make the final decision regarding the recoupment.

Noncompliance discovered during QMET monitoring is remediated through Corrective Action Plans (CAPs), requiring providers to submit their action steps to remedy their non-compliance.
The following language was added based on CMS RAI questions concerning QMET statistical sampling tool:

- A Cognos report is created from the HCBS claims data that is stored in the Commonwealth of PA Enterprise Data Warehouse.
- The Cognos report's data is manually verified.
- The size of the data sample is supported through the use of a sample size calculator available at https://content.metrixmatrix.com/sample.html.
- The report's data is randomly sorted through Microsoft Excel Macros.
- The random data sample that is created by the Microsoft Excel Macros is used to identify the HCBS claims that are to be reviewed for a HCBS provider.

Rate Setting Methodology is examined and analyzed on a yearly basis and adjusted if inconsistent with the waiver.

Systemic issues/defects are addressed through the Department's Bureau of Data and Claims Management, the Bureau of Information Systems and the appropriate systems contractors related to the primary claims processing system (PROMISe™) and its interfaces. When systems issues occur, trouble tickets are generated by the Office of Long Term Living (OLTL) and defects are researched, identified, and corrected by the appropriate systems contractor. All claims impacted by the systems issues during processing are identified by the claims contractor and reprocessed after the correction to the system is made. OLTL sends communications to the providers that are affected making them aware of the issue, what is being done to correct it, and the timeline for completing the correction of the system issue.

When overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken. Providers will receive a series of letters outlining what steps they must take, within a specified time frame, to correct the overpayment. The first letter outlines the overpayments that have been identified and allows the agency to submit further supporting documentation to validate the payment received. The provider is given a 15 day window to comply with this request. If the provider cannot or does not respond, a second letter outlines that they have an additional 15 days to comply or the Department will begin to recover the identified overpayments through either adjustments to future claim payments or a lump sum payback. If OLTL receives no response or the provider agrees with the overpayment, the Department discusses payment methods with the agency and either allows a one-time payment via check, a monthly payback via check, or reduces future payments to that agency until the full amount of the overpayment is recovered.

Accurate and timely claims processing is performed within the MMIS system (PROMSIe™). The claims processing capability accommodates, from receipt through adjudication, the unique identification, editing and auditing, pricing, claim resolution, claim adjustment processing, tracking, controlling, and reporting of every claim transaction as it progresses through all facets of claims processing.

The timeframe for conducting the CAP follow-up is dependent upon the dates for completion identified by the provider. QMET determines the CAP follow-up monitoring schedule and the method (on-site vs in office) based on the action steps that were to be completed. CAPS are to be followed-up on between 30 and 90 days of the last date listed under timeline for completion. The provider is notified of the type of follow-up to be performed 10 business days in advance of the follow-up monitoring. Regardless of the manner of follow-up, all documents reviewed should be of sufficient quantity and scope in order to determine if the action steps have been completed accurately, timely, and in accordance with the approved plan. If the follow-up is performed and all the action items are verified as complete the CAP is closed. If some items remain incomplete, QMET will provide technical assistance in order to assist the provider in remediating any outstanding items and work towards closing the CAP. No CAP is closed until all action steps have been completed.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

OLTL's Medical Assistance fee schedule rates are developed using a market-based approach, using the most current available market data, as opposed to reliance solely on provider-specific cost data. In the few cases where provider data is available, it is reviewed to help identify certain cost components and to inform the fee development process, but no fees are set solely on reported provider costs.

After allowable cost components are identified and market data are reviewed, the process used to calculate the MA fee schedule rates starts with the assumed direct care worker salary expenses. Consideration for all employee-related expenses and productivity adjustments are loaded on top of the wage to calculate a full hourly cost for the direct care worker. Once this amount is established, other program indirect costs are factored in, followed lastly by the loading on of administration expense considerations. The resulting hourly amount is then converted to the appropriate unit definition for the given procedure code (e.g., 15 min, day).

After a rate is developed, OLTL develops geographical fees to reflect service delivery costs in regions across the Commonwealth. Region 1 represents Pittsburgh and surrounding counties, Region 4 represents Philadelphia and surrounding counties, Region 3 represents Harrisburg and surrounding counties and Region 2 represents all other counties. For more information, refer to the regional fees at the following link: http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101249.pdf.

Refer to the following link for a description of the regions and the approach: http://www.pabulletin.com/secure/data/vol42/42-23/1058.html.

Fee schedule rates are established by OLTL to fund services at a level sufficient to ensure participant access to services and to encourage sufficient provider participation so that participants have provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.

Rates for the following services are on the waiver fee schedule: Personal Assistance Services, Adult Daily Living Services (Basic and Enhanced), Community Integration, Home Health Services, Prevocational Services, Residential Habilitation, Residential Habilitation Enhanced staffing, Respite, Structured Day Habilitation, Supported Employment, Therapeutic and Counseling Services and Service Coordination.

Home Adaptations, Assistive Technology, Specialized Medical Equipment and Supplies, Vehicle Modifications, Non-Medical Transportation, Community Transition Services, and Personal Emergency Response Services are all vendor services; vendors may charge what is "usual and customary" for the general public. OLTL does not determine the provider's Usual Customary Charge (UCC). If OLTL had cause to investigate, OLTL would request the provider's documentation to support their UCC (such as their fee schedule), and any other records to show that the provider actually applied the UCC charged to the commonwealth to individuals in the general public.

Other transportation services cannot be authorized for a participant that is receiving Residential Habilitation services. The Bureau of Participant Operations ensures that both Residential Habilitation and Non-Medical Transportation are not mutually present on service plans at time of review. BPO also performs random reviews of those ISPs that go through the auto approval process. In addition, during the biennial provider monitoring process, QMETs review a statically significant sample of ISPs and correlated billing documents.

OLTL provides stakeholders and the general public input on rates in a variety of ways. Feedback is solicited through various forums, including convening a provider workgroup, conducting on-site provider interviews, issuing an all-provider survey, and providing updates at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC). In addition, once rates are determined, OLTL publishes a rate notice in the PA Bulletin with a 30-comment period. Comments received are considered in subsequent revisions to the MA Program Fee Schedule.

The link to OLTL's current Rate Schedule is:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_220889.pdf

Please refer to the public notice at http://www.pabulletin.com/secure/data/vol42/42-23/1058.html for a summary of the rate development process.

When the participant chooses to self-direct some or all of their services, the F/EA is responsible for informing the participant of the established rate for that service.

While monitoring providers on-site, the Quality Management Efficiency Teams request all mileage sheets and/or receipts from buses, taxis or other modes of transportation related to non-medical transportation. The Financial Representative then compares them to the amount billed and paid. Staff then reviews the participant files for the individualized assessment which was performed determining the participants need, and contact notes in HCSIS or SAMS to verify that the service approved was provided.

The fee schedule rates are not adjusted for acuity determination considerations, as differences in acuity are reflected through the use of different staffing ratios or intensity levels for some services. In years when a fee schedule re-base has not been performed, OLTL reviews the fee schedule and applies a cost of living (i.e., inflation factor) adjustment, if needed. No other adjustments were considered to develop the final fee schedule rates.

Although not explicitly stated in Appendix I, the rate development process establishes rates specific to the unit definition for each procedure code (refer to the unit definitions by procedure code in the rate table found at the link below). These unit definitions are consistent with the units of service displayed in Appendix J.
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101249.pdf

Fee schedule services vary depending on the geographic region of the provider as outlined in the region summary found at the link below.
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101252.pdf

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Providers are reimbursed retrospectively based on services provided.

Providers must submit claims through PROMISe™, DHS's MMIS system. This system is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS).

In order to be paid for submitted claims, providers must be enrolled as Medical Assistance providers and entered as such into PROMISe™.

PROMISe™ verifies participant information in the Client Information System (CIS), which contains MA participant's eligibility information, such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates.

PROMISe™ also verifies with HCSIS that the provider(s) and service(s) on the claim are included in the participant's approved waiver service plan.

Service Coordination providers that also serve as Organized Health Care Delivery Systems (OHCDS) providers (further outlined in Appendix I-3, g. ii. below) may serve as the fiscal intermediary for certain specified services. The OHCDS whether subcontracting or directly reimbursing the cost of the service provided by a provider or vender may not bill more than the actual cost of the service. The OHCDS will bill through PROMISe™ and all of the edits, systems checks, etc. as listed above will pertain.

Billing for recipients that choose to self-direct their services is more fully outlined in Appendix E. For Participant-Directed Personal Assistance Services, the F/EA will submit claims to PROMISe™ on behalf of the waiver participant employer. These claims will be billed through PROMISe™, again going through all edit and system checks outlined above. The claims will only be submitted for appropriately approved direct care worker timesheets.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

OLTL ensures that the individual was eligible for Medicaid waiver payment on the date of service, the service was included in the participant's approved service plan, and the services were provided through the use of the following strategies and tools:

Billing validation is done first through PROMISe™. PROMISe™ verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status and effective eligibility dates. PROMISe™ also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the OBRA Waiver.

After validation of the above listed items occurs, the claim information is sent to the Home and Community Services Information System (HCSIS) to be verified against the participants ISP. If any of the information on the PROMISe™ claim is in conflict with the ISP, HCSIS sends an error code to PROMISe™. PROMISe™ then suspends or rejects the claim. This fiscal accountability of

services rendered provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. Resolutions of denied or suspended claims occur through error code notification.

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for and the cost of services provided under the waiver.

OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. As part of the comprehensive on-site monitoring, participant files and service notes are reviewed to ensure that the services authorized have been received.

Claims are reviewed to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type i.e.: personal assistance service, RN Services, etc. This provides an additional check against Service Coordinators who are responsible for ensuring the proper information is entered into HCSIS correctly so providers can bill timely and accurately.
\
All unsupported overpaid claims identified by the TSADF review are reported to the Division of Provider and Operations Management for recoupment purposes.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s)

for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

If a service coordination entity is enrolled as an OHCDS, it may subcontract the services. In its subcontracting activities, the provider must have a written agreement containing the OHCDS and the subcontractor's duties, responsibilities and compensation.

If an OHCDS subcontracts with an entity to provide a vendor good or service, the OHCDS shall ensure the entity complies with 55 Pa. Code Chapter 52.51 related to vendor good or service payment. See http://www.pacode.com/secure/data/055/chapter52/chap52toc.html

OHCDS process:
a. The OHCDS bills the Department for the vendor good or service and then pays the subcontractor. The OHCDS is responsible to ensure that the subcontracting agency is only charging what the good or service costs the general public, and the OHCDS may not charge an administrative fee or any additional costs. Entities eligible for designation as OHCDS for services within this waiver are service coordination entities, all of which render at least one Medicaid service directly (Service Coordination) utilizing its own employees.
b. Eligible entities may request enrollment. Such requests are reviewed and approved by OLTL prior to any service provided through the OHCDS arrangement.
c. As described in Appendix D, individuals are fully informed of their right to choose from all willing and qualified providers and are not required to utilize the OHCDS arrangement. Providers who do not wish to affiliate with an OHCDS may always directly enroll as a provider with the Department.
d. Through robust provider/SC oversight and monitoring, as well as through information garnered through service plan and claims data, OLTL monitors services provided through OHCDS to ensure that the OHCDS has contracted only with providers meeting established minimum qualifications.
e. Through these oversight mechanisms, OLTL will also ensure that the arrangements meet State and Federal requirements
f. The full amount of service dollars is passed through for the provision of service.
g. The State assures financial accountability when an OHCDS arrangement is used by monitoring individual service plans and claims paid to the OHCDS entities through the comprehensive provider and SC monitoring processes performed by OLTL. The state ensures that the payment to the OHCDS does not result in excessive payments through the established process of paying only the cost of the service or good provided.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such

as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

In accordance with 42 CFR 441.310(a)(2), the Commonwealth does not pay the cost of room and board. The fee schedule developed for all waiver services are based solely on service costs and does not include consideration for room and board. These payments are processed through the Commonwealth's MMIS system, PROMISe™, and the cost of room and board is not included.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	58807.91	7471.00	66278.91	152328.00	7967.00	160295.00	94016.09
2	62049.34	7611.00	69660.34	158208.00	8382.00	166590.00	96929.66
3	62623.00	7750.00	70373.00	164087.00	8796.00	172883.00	102510.00

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
4	63636.80	7890.00	71526.80	169967.00	9211.00	179178.00	107651.20
5	63636.91	8029.00	71665.91	175847.00	9626.00	185473.00	113807.09

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	1379		1379
Year 2	1097		1097
Year 3	748		748
Year 4	400		400
Year 5	400		400

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Historically, the average length of stay for this waiver demonstrates an unpredictable pattern from year to year as demonstrated by submitted CMS 372's. In order to make a best estimate of the average length of stay for this renewal, OLTL reviewed the 372 reports for state fiscal years 2012-2013, 2013-14 and 2014-15 then projected forward through the five year waiver renewal period utilizing a computerized forecasting tool. This projected average length of stay for the five year period was then averaged and this average is stated in each table below. The length of stay data projection was calculated utilizing data from DPW's MMIS system, PROMISe and Client Information System (CIS). Specifically, paid claims with a last date of service were obtained from PROMISe and waiver eligibility segments were obtained from CIS for the 3 year period as noted above. This same data is used to calculate and report the actual average length of stay on the CMS 372's.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

OBRA FACTOR D

Column 2 (# Users)

In calculating Factor D - Derivation
The previously submitted 372 report for Fiscal Years 2012/13 was analyzed in combination with pulling similar 372 Report data for SFY 2014/15 to project SFY 2015/16 and SFY 2016/17 annual distinct users. A regression trend was used.
Begin January 2017 eligible OBRA waiver participants that reside in the South West region of Pennsylvania will be moved out of the OBRA waiver and into a new Community Health Choices (CHC) (Managed Care) waiver. Reporting occurred to identified individuals residing in the South West region that should be eligible to move into the CHC waiver based on previous assessments submitted to the State. Additionally, in SFY 2016/17 individuals residing on the South West region between the ages of 18 & 20 who are currently in other waivers but are eligible the OBRA waiver are projected to move into the OBRA waiver. It was determined that there would be minimal impact on the distinct count of annual waiver user for SFY16/17 because turnover is minimal and a user only need to receive a single claim to be counted in the waiver for any particular State Fiscal Year.

Beginning January 2018 eligible OBRA waiver participants that reside in the South East region of Pennsylvania will be moved out of the OBRA waiver and into a new Community Health Choices (Managed Care) waiver. Conversely, in SFY 2017/18 individuals residing on the South East region between the ages of 18 & 20 who are currently in other waivers but are eligible the OBRA waiver are projected to move into the OBRA waiver. For SFY 2017/18 we projected that individuals that either left the OBRA waiver for the CHC waiver or shifted to the OBRA waiver from other waivers beginning January 2018 (from South West Region) would reduce the distinct count participants for projection used for SFY 2018/19. A formula based on supporting documentation (reporting) was used to calculate an overall reduction in users for SFY 2017/18

Beginning January 2019 eligible OBRA waiver participants not reside in the Central region of Pennsylvania will be moved out of the OBRA waiver and into a new Community Health Choices (Managed Care) waiver. Conversely, in SFY 2018/19 individuals residing on the Central region between the ages of 18 & 20 who are currently in other waivers but are eligible the OBRA waiver are projected to move into the OBRA waiver. For SFY 2018/19 we projected that individuals that either left the OBRA waiver for the CHC waiver or shifted to the OBRA waiver from other waivers beginning January 2019 (from South West Region) would reduce the distinct count participants for projection used for SFY 2018/19. A formula based on supporting documentation (reporting) was used to calculate an overall reduction in users for SFY 2018/19. For SFY 2019/20 and 2020/21 a formula based on supporting documentation was used to calculate an overall reduction of all users affected by the three regional shifts.

Column 1 (Unit) – EDW claim data pulled for SFY 2013-14 included the number of units used in association with each paid claim. Using SFY 2013/14 data an average units per person was calculated by dividing the number of units by the number of unduplicated recipients for each service category associated with OLTL's renewed (or amended) waiver application. The average unit per person by service category derived from SFY13/14 data was then multiplied by the projected number of unduplicated users for each service category to obtain the units (per service category) for each estimated year. Note: A percent of "users serviced" ratio for each service category derived from SFY 2013/14 data was applied to the future years to obtain proportionate unduplicated users counts for each service category.

Column 3 (Avg. Units Per User) – Is derived by dividing the estimated units (Column 1) by the number of users (Column 2) for each service category as well as at an aggregate level.

Column 4 (Avg. Cost/Unit) - Is derived by dividing the estimated units (Column 1) by the total cost (Column 5) for each service category.

Column 5 (Component Cost) - At an aggregate level cost is derived by multiplying the previous year's average cost per person by the estimated users previously described for Column 2 (above). At the service category level a weighted average of service category expenditures against the total waiver expenditures is applied.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' was estimated by reviewing paid claims data for the three year period of SFY 2012-2013 through SFY 2014-2015 obtained from DPW's MMIS system, PROMISe for waiver participants that also had acute care paid claims. The data from the 3 year period specified above was then projected forward for the renewal period by dividing acute care costs by unduplicated participants and utilizing a computerized forecasting tool.

Data for Factors D' and G' are obtained from the Enterprise Data Warehouse, which houses all Medicaid claims that are processed through PROMISe™, the state's MMIS. Medicare claims do not run through PROMISe™. As a result, pharmaceuticals furnished to Medicare/Medicaid dual eligibles under the provisions of Part D will never be included in these estimates.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G was estimated by reviewing paid claims data for the three year period of SFY 2012-2013 through SFY 2014-2015 obtained from DPW's MMIS system, PROMISe for waiver participants that also had acute care paid claims. The data from the 3 year period specified above was then projected forward for the renewal period by dividing acute care costs by unduplicated participants and utilizing a computerized forecasting tool.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' was estimated by reviewing paid claims data for the three year period of SFY 2012-2013 through SFY 2014-2015 obtained from DPW's MMIS system, PROMISe for waiver participants that also had acute care paid claims. The data from the 3 year period specified above was then projected forward for the renewal period by dividing acute care costs by unduplicated participants and utilizing a computerized forecasting tool.

Data for Factors D' and G' are obtained from the Enterprise Data Warehouse, which houses all Medicaid claims that are processed through PROMISe™, the state's MMIS. Medicare claims do not run through PROMISe™. As a result,

pharmaceuticals furnished to Medicare/Medicaid dual eligibles under the provisions of Part D will never be included in these estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Daily Living	
Personal Assistance Services	
Residential Habilitation Services	
Respite	
Service Coordination	
Structured Day Habilitation Services	
Behavior Therapy Services	
Nursing Services	
Occupational Therapy	
Physical Therapy Services	
Specialized Medical Equipment and Supplies	
Speech and Language Therapy Services	
Assistive Technology	
Cognitive Rehabilitation Therapy Services	
Community Integration	
Community Transition Services	
Counseling Services	
Home Adaptations	
Non-Medical Transportation	
Nutritional Consultation	
Personal Emergency Response System	
Prevocational Services	
Supported Employment	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						**321383.01**
Basic Day	Full Day	41	118.00	59.80	**289312.40**	
Enhanced Day	Full Day				**26846.08**	
			GRAND TOTAL:			**81096101.65**
			Total Estimated Unduplicated Participants:			**1379**
			Factor D (Divide total by number of participants):			**58807.91**
			Average Length of Stay on the Waiver:			356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		3	119.30	75.01		
Basic Half Day	Half Day	1	130.70	29.90	3907.93	
Enhanced Half Day	Half Day	1	35.10	37.51	1316.60	
Personal Assistance Services Total:						50484414.97
CSLA	15 Min	41	3647.80	4.86	726860.63	
Agency	15 Min	702	8256.40	4.68	27125246.30	
Participant-Directed	15 Min	695	10240.40	3.18	22632308.04	
Residential Habilitation Services Total:						6762663.81
Residential Habilitation Licensed	Per Diem	32	300.40	247.67	2380802.18	
Residential Habilitation Unlicensed	Per Diem	47	249.50	264.15	3097554.98	
Residential Habilitation Enhanced 1:1	Hour	36	1506.80	19.74	1070792.35	
Residential Habilitation Enhanced 2:1	Hour	1	5394.50	39.58	213514.31	
Respite Total:						150958.58
Agency	15 Min	13	775.20	4.62	46558.51	
Participant-Directed	15 Min	18	1615.60	3.59	104400.07	
Service Coordination Total:						2749648.78
Service Coordination	15 Min	1379	100.40	19.86	2749648.78	
Structured Day Habilitation Services Total:						2842783.71
Structured Day Habilitation	Hour	73	1010.10	34.56	2548361.09	
Structured Day Habilitation - Enhanced 1:1	Hour	22	619.70	19.62	267487.31	
Structured Day Habilitation - Enhanced 2:1	Hour	1	686.60	39.23	26935.32	
Behavior Therapy Services Total:						624298.75
Behavior Therapy Services	15 Min	68	441.60	20.79	624298.75	
Nursing Services Total:						10952140.05
Nursing - RN	15 Min	22	2780.30	16.55	1012307.23	
Nursing - LPN	15 Min	87	10367.60	11.02	9939832.82	
Occupational Therapy Total:						208131.66

GRAND TOTAL:	81096101.65
Total Estimated Unduplicated Participants:	1379
Factor D (Divide total by number of participants):	58807.91
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy	15 Min	54	189.40	20.35	208131.66	
Physical Therapy Services Total:						164107.94
Physical Therapy Services	15 Min	44	186.30	20.02	164107.94	
Specialized Medical Equipment and Supplies Total:						27050.42
Specialized Medical Equipment and Supplies	Per Purchase	35	2.30	336.03	27050.42	
Speech and Language Therapy Services Total:						157185.47
Speech and Language Therapy Services	15 Min	33	219.30	21.72	157185.47	
Assistive Technology Total:						1206.89
Assistive Technology	Per Purchase	3	1.30	309.46	1206.89	
Cognitive Rehabilitation Therapy Services Total:						2523300.48
Cognitive Rehabilitation Therapy Services	15 Min	144	1241.00	14.12	2523300.48	
Community Integration Total:						356873.01
Community Integration	15 Min	38	1416.50	6.63	356873.01	
Community Transition Services Total:						185.25
Community Transition Services	Per Purchase	1	19.00	9.75	185.25	
Counseling Services Total:						4496.58
Counseling Services	15 Min	7	54.30	11.83	4496.58	
Home Adaptations Total:						1335438.40
Home Adaptations	Per Adaptation	136	2.50	3927.76	1335438.40	
Non-Medical Transportation Total:						576381.42
Non-Medical Transportation	Per Trip	466	40.50	30.54	576381.42	
Nutritional Consultation Total:						828.95
Nutritional Consultation	15 Min	1	60.20	13.77	828.95	
Personal Emergency Response System Total:						220698.73
Personal Emergency Response System	Monthly	583	10.90	34.73	220698.73	
Prevocational Services Total:						414785.12
Prevocational Services	15 Min	76	854.10	6.39	414785.12	
Supported Employment Total:						117284.54
Supported Employment					117284.54	
				GRAND TOTAL:		81096101.65
				Total Estimated Unduplicated Participants:		1379
				Factor D (Divide total by number of participants):		58807.91
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hour	32	89.70	40.86		
Vehicle Modifications Total:						**99855.10**
Vehicle Modifications	Per Adaptation	10	1.00	9985.51	**99855.10**	
				GRAND TOTAL:		**81096101.65**
				Total Estimated Unduplicated Participants:		**1379**
				Factor D (Divide total by number of participants):		**58807.91**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:						**270955.73**
Basic Day	Full Day	33	124.90	59.80	**246477.66**	
Enhanced Day	Full Day	2	126.30	75.01	**18947.53**	
Basic Half Day	Half Day	1	138.30	29.90	**4135.17**	
Enhanced Half Day	Half Day	1	37.20	37.51	**1395.37**	
Personal Assistance Services Total:						**42511616.97**
CSLA	15 Min	33	3861.90	4.86	**619371.52**	
Agency	15 Min	558	8741.10	4.68	**22826858.18**	
Participant-Directed	15 Min	553	10841.60	3.18	**19065387.26**	
Residential Habilitation Services Total:						**5989569.69**
Residential Habilitation Licensed	Per Diem	26	318.00	247.67	**2047735.56**	
Residential Habilitation Unlicensed	Per Diem	37	264.20	264.15	**2582171.91**	
Residential Habilitation Enhanced 1:1	Hour	36	1595.20	19.74	**1133612.93**	
Residential Habilitation Enhanced 2:1	Hour	1	5711.20	39.58	**226049.30**	
Respite Total:						**123886.07**
Agency	15 Min	10	820.70	4.62	**37916.34**	
Participant-Directed	15 Min	14	1710.50	3.59	**85969.73**	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Coordination Total:						**2313717.80**
Service Coordination	15 Min	1097	106.20	19.86	**2313717.80**	
Structured Day Habilitation Services Total:						**2403815.48**
Structured Day Habilitation	Hour	58	1069.40	34.56	**2143590.91**	
Structured Day Habilitation - Enhanced 1:1	Hour	18	656.10	19.62	**231708.28**	
Structured Day Habilitation - Enhanced 2:1	Hour	1	726.90	39.23	**28516.29**	
Behavior Therapy Services Total:						**524843.55**
Behavior Therapy Services	15 Min	54	467.50	20.79	**524843.55**	
Nursing Services Total:						**9174236.68**
Nursing - RN	15 Min	17	2943.50	16.55	**828153.72**	
Nursing - LPN	15 Min	69	10976.20	11.02	**8346082.96**	
Occupational Therapy Total:						**175447.52**
Occupational Therapy	15 Min	43	200.50	20.35	**175447.52**	
Physical Therapy Services Total:						**138314.92**
Physical Therapy Services	15 Min	35	197.10	20.05	**138314.92**	
Specialized Medical Equipment and Supplies Total:						**22910.94**
Specialized Medical Equipment and Supplies	Per Purchase	28	2.30	355.76	**22910.94**	
Speech and Language Therapy Services Total:						**131127.98**
Speech and Language Therapy Services	15 Min	26	232.20	21.72	**131127.98**	
Assistive Technology Total:						**1206.89**
Assistive Technology	Per Purchase	3	1.30	309.46	**1206.89**	
Cognitive Rehabilitation Therapy Services Total:						**2114958.55**
Cognitive Rehabilitation Therapy Services	15 Min	114	1313.90	14.12	**2114958.55**	
Community Integration Total:						**298290.33**
Community Integration	15 Min	30	1499.70	6.63	**298290.33**	
Community Transition Services Total:						**196.08**
Community Transition Services	Per Purchase	1	19.00	10.32	**196.08**	
Counseling Services Total:						**3401.12**
Counseling Services	15 Min	5	57.50	11.83	**3401.12**	
Home Adaptations Total:						**1122749.10**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Adaptations	Per Adaptation	108				