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:
Several changes have been included in this application to renew the Attendant Care Waiver changes have been made to update the Waiver to:
• reflect current practice and policies to ensure consistent implementation;
• address issues identified in the Corrective Action Plan with CMS;
• emphasize OLTL administrative authority over the waiver, enhance oversight and monitoring of providers and contractors, and provide for a comprehensive quality improvement strategy;
• polish and enhance waiver language; and
• Incorporate waiver processes and service coverage to improve quality of care outcomes for members.

This Waiver renewal reflects input and consideration from an array of stakeholder input, including feedback from the Centers for Medicare &Medicaid Services (CMS) on necessary improvements to program features and operation.

Notable changes in each Appendix in this renewal include:
Appendix A – Administrative Authority
• Defines OLTL as a division within the Single State Medicaid Agency that operates the waiver, removing references to the dual deputate with Department of Aging.
• Adds FMS (PPL) to the list of entities identified in Appendix A to which OLTL delegates certain administrative functions.
• Clarifies OLTL's oversight of contracted entities throughout the appendix, including the AAAs, the IEB and the FMS, affirming the responsibility of OLTL as the ultimate authority.

Appendix B – Participant Access and Eligibility
• Simplifies and provides clarifying language regarding additional targeting/eligibility criteria for the Attendant Care waiver.
• Adjusts minimum service requirements within the waiver to 2 services per month, including Service Coordination.
• Removes specific reference to the MA 51, replacing with more general physician certification language to allow greater flexibility.
• Clarifies the individuals conducting annual re-evaluations (Service Coordinators) of level of care, and strategies used by OLTL to ensure the process is conducted in accordance with Commonwealth requirements, and to oversee and monitor the entities in this effort.
• Clarifies that providers must have processes for participants with limited English proficiency to access language services.

Appendix C – Participant Services
• Clarifies allowable functions performed by caregivers including:
– Removes references to minor children, as waiver does not include children; and

– Includes provisions for OLTL oversight and monitoring strategies.
• Service definitions were modified to improve clarity, but in most instances were not substantively changed.
• Provider qualifications were improved for consistency, but again, are substantively unchanged.
• Modifies Service Coordination service definition to clarify the Service Coordinator's role, improve the quality of service delivered to individuals in the waiver and clarifies the scope of the service in the waiver.
Appendix D – Participant-Centered Planning and Service Delivery
• Modifies the language indicating that SC entities could serve as FMS providers and refined the description of services that they may render while serving as an Organized Healthcare Delivery System (OHCDS).
• Incorporates the standard, OLTL developed participant information materials that must be shared with individuals to enable them to play a leadership role in the design of their service plan.

Appendix E – Participant Direction
• Minor changes throughout appendix to use consistent terminology and to note that understandable information and training is available to individuals.
• Augments language describing the functions performed by the FMS entity, and the monitoring strategies OLTL will undertake.

Appendix F – Participant Rights
• Added new language to describe the procedures for advising individuals of their opportunities for Fair Hearing and affirms that the information shared is developed and/or approved by the Commonwealth.
• Provides clarification on State Grievance/Complaint system.

Appendix G – Participant Safeguards
• Reflects current practice and demonstrates that necessary processes are in place to protect the health and welfare of waiver participants.

Appendix H – Quality Improvement Strategy
• Reflects the ongoing work with CMS, and describes the discovery, remediation and systems improvement processes that will be used for this renewal, and across the OLTL waivers.

Appendix I – Financial Accountability
• Clarifies that providers are subject to all requirement standards specified in 55 PA Code Ch. 52, including audit requirements and claims submission.
• Adds language to reflect systems in place to prevent payment for unauthorized services.
• Provides details regarding the methodology and process for establishing rates.
• Adds description of the flow of billing when an OHCDS is the provider and for flow of billing when FMS is used for persons self-directing their care.

Appendix J – Cost Neutrality Demonstration
• Modifies projections of unduplicated recipients and expenditures based upon the most recent 372 report and patterns of care.

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*):
Attendant Care 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.0277
Waiver Number:PA.0277.R04.00
Draft ID: PA.10.04.00

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

Regular Waiver

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

Approved Effective Date: 07/01/13

1. Request Information (2 of 3)

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

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**

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

  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [x] **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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Pennsylvania's Attendant Care program began as a State-funded program in 1987 as a result of The Attendant Care Services Act (Act-1986-150, 62 P.S. § 3051 et seq.), also known as Act 150. Act 150 required the Department of Public Welfare to establish Attendant Care services for "those mentally alert, but severely physically disabled individuals who are at the greatest risk of being in an institutional setting". The Attendant Care program provides for basic and ancillary services that enable an eligible person to remain in their home and community rather than an institution and to carry out functions of daily living, self-care and mobility. An eligible person as defined under Act 150 is any individual with physical disabilities who is mentally alert and at least 18 years of age, but less than 60, who, in addition to requiring attendant care services, experiences any medically determinable physical impairment which can be expected to last for a continuous period of 12 months or may result in death. That person must also be capable of selecting, supervising and, if needed, firing an attendant and be capable of managing their own financial and legal affairs. The term "mentally alert" in Attendant Care programs in Pennsylvania has traditionally been used to distinguish between those persons with physical disabilities and persons with intellectual disabilities or persons with a mental health diagnosis. In addition, mentally alert has been operationally defined as meeting the eligibility criteria for Act 150.

In the early 1990's, the Department began looking to Federal funding in order to expand the Attendant Care program and, in 1995, received approval from the Health Care Financing Agency (now CMS) for the Attendant Care waiver. The Attendant Care waiver mirrors the legislative intent of Act 150 by offering individuals age 18 to 59, who are mentally alert with physical disabilities and who are Medicaid eligible, the choice of Home and Community-Based Services to avoid institutionalization.

The Attendant Care waiver has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. Services available through the Attendant Care waiver include Personal Assistance Services, Service Coordination, Personal Emergency Response System and Community Transition Services – services designed to support individuals to live more independently in their homes and communities.

The Department of Public Welfare (Department), as the State Medicaid agency, retains authority over the administration and implementation of the Attendant Care Waiver. The Office of Long-Term Living (OLTL), as part of the single State Medicaid Agency (SMA), is responsible for ensuring that the Attendant Care Waiver operates in accordance with applicable Federal 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. OLTL administers Attendant Care 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 Attendant Care 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.

Through this renewal, the Commonwealth proposes to:
• Polish/Enhance waiver language;
• Address issues identified in Corrective Action Plan;
• Reflect current practice;
• Emphasize OLTL administrative authority of the waiver programs, enhance oversight and monitoring of providers and contractors, and provide for a comprehensive quality improvement strategy; and
• Incorporate waiver processes and service coverage to improve quality of care outcomes for members.

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/MR.

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

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

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, 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:
OLTL has been, and continues to be, committed to a meaningful stakeholder engagement process for the Waiver renewals. OLTL has an open and continuous communication strategy with a wide array of stakeholders. As such, feedback has been collected through multiple forums in recent years (past 2-3 years) and has been utilized to prepare for the renewal and determine proposed changes during the renewal process.

• Various venues and formats were used to obtain stakeholder feedback, which included:
o Comments regarding the draft service definitions for State Fiscal Years 11/12.
o Various workgroups.
o Provider association meetings, conferences and presentations.
o Advisory committee discussions.

• The following stakeholder engagement process was used:
o Facilitated stakeholder feedback on key issues.
o Aligned recommendations with state priorities.

Specifically in the drafting of the renewal, the following strategies were undertaken:
• Reviewed major areas of proposed changes with the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC) on February 12, 2013 and requested feedback.

• Distributed a comprehensive overview of the proposed Waiver renewal changes to the OLTL Subcommittee on 2/12/2013 for a public comment period on all changes prior to submission of the renewal request.

• Reviewed major areas of proposed changes with the MAAC on February 28, 2013 and requested feedback.

• Feedback was also collected from the public via a comment page connected to the OLTL website. Email comments were collected and reviewed by OLTL during the Attendant Care Waiver renewal process.

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: Chief of Staff

Agency: Office of Medical Assistance Programs, Department of Public Welfare

Address: P.O. Box 2675

Address 2: Room 515, Health and Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17105-2675

Phone: (717) 772-6147 **Ext:** ☐ **TTY**

Fax: (717) 772-6366

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: Bonnie Rose

State Medicaid Director or Designee

Submission Date: May 9, 2013

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

Last Name: Gordon

First Name: Vincent

Title: Deputy Secretary

Agency: Office of Medical Assistance Programs, Department of Public Welfare

Address: P.O. Box 2675

Address 2: Room 515, Health and Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17101

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

Fax: (717) 787-4639

E-mail: vingordon@pa.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

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

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

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

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

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 (OLTL)
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

   The Secretary of the Department of Public Welfare, the State Medicaid Director (Deputy Secretary of the Office of Medical Assistance Programs (OMAP)) and the Deputy Secretary of the Office of Long-Term Living meet weekly to discuss operations of the waivers and other long term living programs. In addition, OLTL and OMAP policy staff meets regularly to review and gain consent on Waiver policies, rules and guidelines.
   Descriptions of the functions of the operating divisions within the Department, including OLTL and OMAP, are available (through links) on the following Department of Public Welfare website http://www.dpw.state.pa.us/dpworganization/index.htm. The specific roles and responsibilities of these entities in the administration of the waiver are further delineated in waiver policies and procedures.

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

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative

functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

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

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

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

Through the current Title XIX Medicaid Waiver Grant Agreement, OLTL contracts with 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 Attendant Care waiver. Specifically, the Independent Enrollment Broker (IEB) 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 Nursing Facility 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 local AAA for the level of care determination;
• Assist the participant to complete the financial eligibility determination paperwork; and
• Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms.

OLTL also contracts with one Fiscal Employer/Agent (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;
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis and as requested by the participant, Service Coordinator and OLTL (Budget Authority only).

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

Administration and oversight of these contracts falls within the purview of OLTL and the Office of Medical Assistance Programs (OMAP). The assessment methods used to monitor performance of contracted entities are described 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 Attendant Care 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 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 Attendant Care 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 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 Broker (IEB). The IEB facilitates eligibility determinations for multiple home and community-based waivers managed by OLTL. The IEB does not provide any ongoing direct services to the participant. The IEBs 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 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 during this period of renewal, through work with CMS on a Corrective Action plan, and in response to CMS recommendations on the evidence report, to strengthen the methods for overseeing entities performing administrative elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring.

OLTL oversees and monitors the performance of the 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) (whose composition and function are described in greater detail in Appendix H) to discuss the areas of non-compliance and develop statewide strategies to reverse negative

trends. Strategies include issuing or re-issuing instructions to the AAA community regarding performance obligations, implementing or revising training for AAAs on their responsibilities, or recommending contract revisions.

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

If the F/EA exhibits noncompliance in any area of the waiver or contract, 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 oversees the performance of the enrollment function which has been delegated to the Independent Enrollment Broker. The Independent Enrollment Broker is monitored annually on contracted performance measures. In addition to the annual contract monitoring, OLTL oversees ongoing operation through IEB performance on contracted performance measures that are collected monthly from the IEB 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 Broker fails to meet established performance measure standards it must respond to the findings and remediate areas of non-compliance. If the Independent Enrollment Broker 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

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: Semi-annually

Performance Measure:
Number and percent of Service Coordination agencies that meet waiver obligations regarding ongoing level of care determinations Numerator: Total number of SCAs who meet waiver obligations regarding ongoing level of care determination Denominator: Total number of SCAs reviewed

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

Provider Monitoring

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:
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):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of contractual obligations met by the F/EA Numerator: Total number of contractual obligations that were met by the F/EA Denominator: Total number of contractual obligations of the F/EA

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of contractual obligations met by the F/EA regarding the execution of Medicaid provider agreements. Numerator: Total number of contractual obligations that were met by the F/EA Denominator: Total number of contractual obligations of the F/EA

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Bureau of Quality and Provider Management (BQPM) reviews AAAs regarding the initial Level of Care, annual reevaluation of Level of Care, F/EA and enrollment functions. The BQPM uses standard monitoring tools which outline the provider requirements as listed in the waiver and the Fiscal/Employer Agent (F/EA) contract, including LOC determination, F/EA, and enrollment functions. The BQPM verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the administrative data and monitoring reviews identify AAAs are noncompliant with requirements related to Level of Care determinations and/or enrollment functions as outlined in the waiver or grant agreements, the agency receives written notification of noncompliance with a request for a Corrective Action Plan (CAP). The CAP is due to the BQPM within 15 working days upon receipt. BQPM staff reviews and accepts/rejects the CAP within 30 working days. Follow up by the BQPM occurs to ensure the CAP was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue, technical assistance is provided by the Bureau of Quality and Provider Management (BQPM) and the Bureau of Participant Operations (BPO). This same process is applied to both the F/EA when non-compliance is found with contractual obligations regarding the execution of Medicaid provider agreements.

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** 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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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)**	18	59	
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐

	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

To be eligible to enroll in the Attendant Care Waiver and receive waiver services, a participant must meet all of the following conditions:

1. The participant must be 18 through 59 years of age.
2. The participant must be a mentally alert individual with a physical disability who meets all of the following requirements:
a. Experiences any medically determinable physical impairment which can be expected to last for a continuous period of not less than 12 months or that may result in death.
b. Is capable of selecting, supervising and, if needed, firing an attendant.
c. Is capable of managing his/her own financial and legal affairs.
d. Because of physical impairment, the participant requires assistance to perform functions of daily living, self-care, and mobility including, but not limited to, those functions included in the definition of Personal Assistance Services.
e. Is capable of directing his or her own care.

3. The participant must be a resident of Pennsylvania.

4. The participant must have completed an Attendant Care Signature page indicating they wish to receive Attendant Care Services.

Historically the Attendant Care Program exists pursuant to the Attendant Care Services Act (Act-1986-150, 62 P.S. § 3051 et seq.), also known as Act 150. Act 150 provides for basic and ancillary services that enable an eligible person to remain in their home and community rather than an institution and to carry out functions of daily living, self-care and mobility. One of the founding eligibility requirements contained in this legislation is that the person receiving services must also be capable of selecting, supervising and, if needed, firing an attendant and be capable of managing their own financial and legal affairs.

The term “mentally alert” in attendant care programs in Pennsylvania has traditionally been used to distinguish between those persons with physical disabilities and persons with an intellectual disability or persons with a mental health diagnosis. In addition, mentally alert has been operationally defined as meeting the eligibility criteria for Act 150 (see above). The Attendant Care program has been rooted in the Independent Living philosophy and promotes freedom of individual choice.

As described below in B-1- c, OLTL provides for the continuation of services to participants whose age exceeds the maximum age limit that applies to entrance to the waiver.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants who are receiving services through the Attendant Care Waiver before turning age 60 may choose either to:
1. continue to remain in the Attendant Care Waiver upon reaching the age of sixty, or
2. transfer their services to the Aging Waiver upon reaching the age of sixty.

The individual's Service Coordinator will provide information about the Aging waiver to transition-age participants so that they may make a fully informed decision. Furthermore, decisions will be discussed as a part of the person-centered planning process.

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	10000
Year 2	10000
Year 3	10000
Year 4	10000
Year 5	10000

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	9800
Year 2	9800
Year 3	9800
Year 4	9800
Year 5	9800

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person Re-balancing Demonstration	

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person Re-balancing Demonstration

Purpose *(describe):*

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

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

Waiver Year	Capacity Reserved
Year 1	72
Year 2	77
Year 3	82
Year 4 (renewal only)	87
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

All individuals that are eligible for the waiver will be served. In the event that a waiting list for waiver services becomes necessary, determined based upon date of application for services and according to the following order of priority:

1. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community OR Individuals who are at imminent risk of nursing home placement. Individuals who currently reside in the community and are at imminent risk of nursing facility placement within 24-72 hours or less.
2. Individuals who are in the community but can wait more than 72 hours for home and community-based services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

- [x] **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 4)

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

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

- ◉ **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 4)

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 4)

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 4)

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-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- **Other**

Specify:

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

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

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

AAA Assessors must meet the following qualifications:

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

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

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

Individuals conducting redeterminations (Service Coordinators) must meet the provider qualifications as outlined below and in Appendix C.

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

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

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

1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; and
2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board; and
3. A physician certifies that the individual is NFCE; and
4. The care and services are either
a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or
b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

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

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

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

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

The same instrument is used for institutional and initial waiver level of care. A different instrument is used for reevaluations. Service Coordinators utilize the Case Management Instrument (CMI) to conduct the annual reevaluation of level of care. The CMI is the comprehensive assessment tool utilized by all OLTL home and community-based service programs to collect information about the participant's strengths, capacities, needs, preferences, health status, risk factors and desired goals, which is used to develop the participant's Individual Service Plan (ISP). A Section of the CMI mirrors the information collected in the LOCA, including information on medical changes, recent hospitalizations and changes in functional status (ADLs and IADLs). The information collected on the CMI is compared to the information collected in the individual's previous evaluation or reevaluation which assists the Service Coordinator to identify changes and make the level of care reevaluation eligibility determination.

Through a retrospective review of a valid statistical sample of service plans, OLTL monitors that the CMI is yielding results comparable to the initial level of care assessment conducted by the local AAA.

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

Initial Level of Care Evaluation – OLTL uses the following process to determine an individual's initial level of care:
• The participant first applies for Attendant Care Waiver services through the statewide Independent Enrolling Agency.
• The IEB assists the participant with obtaining a completed physician certification form from the participant's physician (M.D. or D.O.).
• The physician completes the physician certification form indicating the physician's diagnosis and level of care recommendation.
• The IEB forwards the physician's certification form along with a request for a level of care assessment to the local AAA.
• The AAA assessor visits the participant and uses the LOCA form to identify information regarding the participant's medical status, recent hospitalizations, and functional ability (ADLs and IADLs). The same level of care tool, the LOCA, is used in all 67 counties for all individuals entering the waiver, and is the same tool used to determine institutional LOC.
• The IEB 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 AAA is responsible for making the final level of care evaluation decision subject to OLTL oversight.

Annual Reevaluation – OLTL uses the following process for the annual reevaluation of current waiver participants:
• The participant's Service Coordination Entity is responsible for completion of the annual reevaluation of the level of care.
• The Service Coordinator completes the annual reevaluation by visiting the participant and completing the Care Management Instrument.
• The CMI, the standardized needs assessment form, mirrors the information collected in the LOCA, including information on medical changes, recent hospitalizations, and changes in functional status (ADLs and IADLs).
• The information collected on the CMI is compared to the information collected in the individual's previous evaluation or reevaluation.
• The Service Coordination Entity is responsible for making the level of care reevaluation determinations, subject to OLTL oversight.
OLTL ensures that the annual reevaluation 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 as referenced in the Quality Improvement section below..

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

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

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

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

Individuals performing reevaluations are Attendant Care waiver service coordinators. These individuals must meet the following qualifications:
1. Have a bachelor's degree including or supplemented by at least 12 college-level credit hours in sociology, social welfare, psychology, gerontology or another behavioral science.
2. A combination of experience and training which adds up to four years of experience, and education which includes at least 12 semester hours of college-level courses in sociology, social work, social welfare, psychology, gerontology or other social science.
• Experience includes: coordinating assigned services as part of an individual's treatment plan; teaching individuals living skills; aiding in therapeutic activities; and providing socialization opportunities for individuals.

• Experience does not include: Providing hands-on personal care for people with disabilities or individual over the age of 60; maintenance of an individual's home, room or environment; and aiding in adapting the physical facilities of an individual's home.

Service Coordination Supervisors must meet one of the following:
1. Have at least three years experience in public or private social work and a bachelor's degree.
2. Have a combination of experience and education equaling at least three years of experience in public or private social work including at least 12 college-level credit hours in sociology, social work, psychology, gerontology or other related social science. Graduate coursework in the behavioral sciences may be substituted for up to two years of the required experience. Behavioral sciences include, but are not limited to, anthropology,

counseling, criminology, gerontology, human behavior, psychology, social work, social welfare, sociology and special education.
OLTL has developed training curriculum and provides periodic regional training to Service Coordinators through the initial OLTL Service Coordination training and the Individual Service Plan (ISP) training. This curriculum provides specific instruction on the execution of the reevaluation for level of care, among other competency areas. In addition, Service Coordinators must meet the training requirements as outlined in 55 PA Code Chapter 52.27.

During the on-site biennial provider monitoring visits, the QMET reviews employee personnel files to ensure individuals performing reevaluations meet the qualifications outlined in 55 PA Code Chapter 52 and above.

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

On an annual basis from the date the initial evaluation is completed, the Service Coordinator will meet with the participant in their home to reassess the participant's need for waiver services and complete the CMI. In addition, each Service Coordination Entity maintains its own tickler system to complete timely reevaluations and maintain consistency in service. Service Coordinators are required to conduct reevaluations more frequently, if needed, when there are changes in a participant's functioning and/or needs.

After the reevaluation is completed, the Service Coordinator enters the information in a service note in HCSIS. The reevaluation information is maintained in the participant's file which is subject for review during OLTL biennial provider monitoring visits and retrospective service plan review process as described in the Quality Improvement section of Appendix D.

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

Documentation of the participant's initial level of care determination is electronically maintained in SAMS.

In addition, Service Coordinators maintain copies of evaluations and reevaluation 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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of all new enrollees who have level of care determination,

prior to receipt of waiver services Numerator: Total number of all new enrollees who have level of care determination, prior to receipt of waiver services Denominator: Total Number of all new enrollees

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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: Semi-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: Semi-annually

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants with annual re-determination of LOC within 12 months of initial LOC evaluation or within 12 months of last annual LOC evaluation Numerator: Total number of waiver participants with annual re-determination of LOC within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation ***See Main-B-Optional for rest

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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of initial LOC determination that adhered to timeliness and specifications Numerator: Total number of initial LOC determinations, that adhered to timeliness and specifications Denominator: Total number of new enrollees

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of annual LOC reevaluations that adhered to timeliness and specifications Numerator: Total number of annual LOC reevaluations, that adhered to timeliness and specifications Denominator: Total number of waiver

participants reviewed

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

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

Data Aggregation and Analysis:

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

	Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** 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 Attendant Care Waiver services and the participant is determined to likely require Nursing Facility level of care, the individual will be:

• Informed by the IEB of all available home and community-based service delivery alternatives, including the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over; and,

• Given the choice of receiving Nursing Facility institutional services, waiver services, LIFE program services as appropriate, or no services

Participant Freedom of Choice of Care Alternatives

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

Participant Freedom of Choice of Providers

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

The Service Coordination Entity is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial Individual Service Plan, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination Entity is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed, completed and signed the form. Notation is made in the participant’s record of receipt of the

form; completed forms are maintained in the participant's file with the Service Coordination Entity. OLTL monitors participant receipt of the forms as part of its biennial provider reviews.

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

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

Appendix B: Participant Access and Eligibility

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

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

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	Personal Assistance Services		
Statutory Service	Service Coordination		
Other Service	Community Transition Services		
Other Service	Participant-Directed Community Supports		
Other Service	Participant-Directed Goods and Services		
Other Service	Personal Emergency Response System (PERS)		

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

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

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living:
• Activities that are incidental to the delivery of the Personal Assistance to assure the health, welfare and safety of the participant such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.
• Services to accompany the participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Assistance Services may only be funded through the waiver when the services are not covered by the State Plan, 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 are not included in the scope of Personal Assistance.

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 Participant-Directed Community Supports or Participant-Directed Goods and Services.

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 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 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 Services workers must:
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Be 18 years of age or older;
• Possess basic math, reading, and writing skills;
• Possess a valid Social Security number;
• Submit to a criminal record check;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63);
• Have the required skills to perform Personal Assistance Services as specified in the participant's service plan;
• Complete any necessary pre/in-service training related to the participant's service plan;
• Agree to carry-out outcomes included in the participant's service plan; and
• Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Employer Agent/OLTL
Frequency of Verification:
At least every two years and more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: 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

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, include 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.
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 parole and probation functions, legal services, public guardianship, special education and foster care.
• 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:
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

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—household products, dishes, chairs, tables;
• Moving Expenses;
• Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement;
• Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating;
• Items for personal and environmental health and welfare (Example personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.)
The provision of this service may be facilitated by an Organized Health Care Delivery System as described in Appendix I.3.g.ii.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Community Transition Services are furnished only to the extent that they are reasonable and necessary, as determined through the ISP development process; clearly identified in the service plan and the participant is unable to meet such expense; or when the services 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 OLTL.

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	Transition 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:
Transition 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
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
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:
Participant-Directed Community Supports

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

Supports will be available to assist the participant in performing employer-related duties and responsibilities through the Fiscal/Employer Agent (F/EA) and Service Coordinator.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participant-directed Community Support services may only be funded through the waiver when the services are not covered by the State Plan, 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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
•• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be at least 18 years of age;
• Possess a valid Social Security number;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• When required by the participant, the individual must be able to demonstrate the capability to perform health maintenance activities or receive necessary training.
Verification of Provider Qualifications
Entity Responsible for Verification:
The participant and Fiscal/Employer Agent
Frequency of Verification:
•At time of selection of the individual worker to be hired
• F/EA will verify provider qualifications are met during the provider employment process and will enter into a provider agreement with each provider on behalf of the State Medicaid agency

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Participant-Directed Goods and Services

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

Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan. These items must address an identified need in the participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:
• Decrease the need for other Medicaid services;
• Promote or maintain inclusion in the community;
• Promote the independence of the participant;
• Increase the individual's health and safety in the home environment;
• Develop or maintain personal, social, physical or work-related skills;
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support; or
• Fulfill a medical, social or functional need as identified in the participant's individual service plan.

Participant-directed goods and services are purchased from the participant's Individual Spending Plan.

•
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participant-directed Goods and Services may only be funded through the waiver when the services are not covered by the State Plan, 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.

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

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

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

Experimental or prohibited treatments are excluded.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
• Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Be at least 18 years of age;
• Possess a valid Social Security number;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• When required by the participant, the individual must be able to demonstrate the capability to perform health maintenance activities or receive necessary training.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal/Employer Agent
Frequency of Verification:
• At time of enrollment and as necessary
• The F/EA will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the State Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
N/A

Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavior needs;
• Vendor/Fiscal Employer must enter into a Medicaid Provider Agreement with each provider on behalf of the State Medicaid Agency; and
• Providers must meet applicable State and local regulations and/or Medicaid provider qualifications for the type of service the provider/supplier is providing as written in the participant's service plan.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

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

Appendix C: Participant Services

C-1/C-3: 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 (PERS)

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	Home Health Agency
Agency	Durable Medical Equipment and Supply Company
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 (PERS)

Provider Category:

Agency

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; 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 (PERS)

Provider Category:
Agency
Provider Type:
Durable Medical Equipment and Supply Company
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance; and
• Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with Department standards, regulations, policies and procedures relating to provider

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

Verification of Provider Qualifications

Entity Responsible for Verification:
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 (PERS)

Provider Category:
Agency
Provider Type:
Vendors of Personal Emergency Response Systems
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
• Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
• Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
• Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
• Have Commercial General Liability insurance;
• All PERS installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply, including any applicable business license; and
• Organization must have capacity to provide 24-hour coverage by trained professionals, 365 days/year.
Individuals working for or contracted with agencies must meet the following standards:
• Be at least 18 years of age;
• Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 PA Code Chapter 52;
• Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
• Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
• Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
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: 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):

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

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

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

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

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

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

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

Family members can provide Personal Assistance Services; however, the following exclusions apply:
• The Attendant Care Waiver will not pay for services furnished by a spouse.

• The Attendant Care Waiver will not pay for services furnished by a legal guardian.

• The Attendant Care Waiver will not pay for services furnished by an active Power of Attorney (POA) of a participant. This requirement may be waived under special circumstances, if reviewed and approved by OLTL.

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

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

OLTL will review participant records as part of the biennial monitoring to ensure that Service Coordinators have

monitored the provision of services and documented their monitoring activities in accordance with OLTL protocols.

Participants that employ family members to provide Personal Assistance Services, like all providers, must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews authorized billable units through the 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 a continuous open enrollment of providers and does not limit provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available upon request from the OLTL, and are also available to potential providers online through the DPW website http://www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm

As a condition of participation in the Attendant Care 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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and Percent of newly enrolled waiver providers who meet required licensure, regulatory, and applicable waiver standards prior to service provision Numerator: Total number of new waiver providers meeting required licensure, regulatory and applicable waiver standards prior to service provision (providers newly enrolled) Denominator: Total number of new waiver provider applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers continuing to meet applicable licensure/ certification, regulatory and applicable waiver standards following initial enrollment Numerator: Total number of providers continuing to meet applicable licensure/certification, regulatory and applicable waiver standards following initial enrollment Denominator: Total number of providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

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 monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of newly enrolled non-licensed/non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision
Numerator: Of those applying during the reporting period, the total number of non-licensed/non-certified providers meeting regulatory and applicable waiver standards prior to service provision ***See Main-B-Optional for rest

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed/non-certified providers who continue to meet waiver provider qualifications Numerator: Of those reviewed during the reporting period, the total number of non-licensed/non-certified providers continuing to meet regulatory and applicable waiver standards following initial enrollment
*****See Main-B-Optional for rest**

Data Source (Select one):

Other
If 'Other' is selected, specify:
Provider Monitoring

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:
Number and percent of contractual obligations met by the F/EA Numerator: Total number of contractual obligations met by the F/EA Denominator: Total number of contractual obligations of the F/EA

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

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**

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of providers meeting provider training requirements Numerator: Of those reviewed during the reporting period, the total number of providers meeting provider training requirements. Denominator: Total number of providers reviewed during the reporting period (quarter)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The 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**
☐ **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 D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan (ISP)

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 provide only the following services by serving as an Organized Health Care Delivery System (OHCDS).
• Community Transition Services; and/or
• Personal Emergency Response System (PERS).

Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS or select any other enrolled qualified provider. The Service Coordination provider, 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 the Case Management Instrument, 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. 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 LOCA tool to determine whether the participant meets the Nursing Facility level of care. In addition a physician completes a physician certification form which indicates the physician's level of care recommendation.

At the time of enrollment, the independent enrollment broker completes the Case Management Instrument, OLTL's standardized needs assessment. The CMI secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator uses the information gathered from the level of care assessment and the standardized needs assessment to develop the participant's Individual Service Plan.

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

How the participant is informed of the services available under the waiver:
The Service Coordinator is responsible to ensure all waiver participants are informed of home and community-based services funded through the Attendant Care Waiver. The Service Coordinator describes and explains the concept of participant-centered service planning, as well as the types of services available through the Attendant Care 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 a copy of the 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 is demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being rendered by the provider. The Service Coordinator must communicate service plan approval and changes to the participant and the appropriate service provider to ensure that service delivery is consistent with the approved ISP. The Quality Management Efficiency Teams (QMET) 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.

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 and CMI that is completed during a face-to-face interview with the individual at the time of enrollment. Through the Level of Care Assessment and CMI 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.

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 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 entities) that provide the services in their service plan. The toll-free HelpLine information is provided to participants at time of enrollment, at annual reevaluations, and during the Service Coordinator's participant service monitoring visits.

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

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

• The OLTL Service Provider Choice Form emphasizes to participants that they have the right to choose any qualified provider, and that they cannot receive service coordination and 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 initial ISPs. The Service Coordinator, in conjunction with the participant, is responsible to modify the ISP if the participant's needs change.

When there is a change in the ISP, the Service Coordinator submits that potential change to OLTL through the 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 services 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):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

• Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. During monitoring contacts the SC is responsible for discussing the following information with the participant and documenting the information in HCSIS service notes for review by OLTL:
 The participant is receiving the amount, frequency, and duration of services that are in the approved ISP.
 The participant is receiving the authorized services that are in the ISP.
 The participant is receiving the amount of support necessary to ensure health and safety.
 If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes
 There is no duplication of services including waiver and non-waiver services.
 Contacts with individuals, families and providers.
 Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP.
 That the recommended and chosen services are being implemented.
 That the back-up plan is effective and how often it has been used.

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

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

OLTL reviews and approves the ISP through 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 under utilization) and spending patterns. The F/EA is also responsible for providing written notification to the Service Coordinator of any common law employer who does not submit timesheets for two or more consecutive payroll periods.

b. Monitoring Safeguards. *Select one:*

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

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

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

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

Service Coordination entities may provide the following services under an Organized Health Care Delivery System (OHCDS):
- Home Delivered Meals;
- Community Transition Services;
- Non-Medical Transportation;
- Accessibility Adaptations, Equipment, Technology and Medical Supplies; and
- Personal Emergency Response System (PERS).

Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS, or select any other enrolled qualified provider. The Service Coordination 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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants with Individual Service Plans (ISPs) adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment Numerator: Total number of waiver participants with ISPs adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment. ***See Main-B-Optional for rest

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:

Performance Measure:
Number and percent of waiver participant satisfaction survey respondents who reported unmet needs. Numerator: Total number of participants reporting unmet needs in returned surveys. Denominator: Total number of returned surveys with yes or no answers

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**	☐ **Weekly**	☑ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: Services My Way
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 100% of returned surveys
	☑ **Other** Specify: Three times a year	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants who have service plans that address the participant's goals Numerator: Total number of waiver participants who have ISPs that address participant goals 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:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of Individual Service Plans and related service plan activities that comply with who develops the plan, who participates in the process and the timing of the plan development Numerator: Total number of ISPs that comply regarding who develops the service plan, who participates in the process and the time of the plan Denominator: Total number of ISPs 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*	**Frequency of data aggregation and analysis***(check each that applies):*

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

Performance Measure:
Number and percent of Individual Service Plans and related service plan activities that comply regarding how waiver services and other non-waiver services are coordinated. Numerator: Total number of ISPs that comply regarding how waiver and other non-waiver services are coordinated. Denominator: Total number of ISPs 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:

Performance Measure:
Number and percent of waiver participants whose Individual Service Plan included a risk factor assessment and needs assessment instrument Numerator: Total number of waiver participants who had ISPs that included a risk factor assessment and needs assessment instrument Denominator: Total number of 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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of participants with Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date Numerator: Total number of participants with ISPs reviewed and/or revised annually 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:

Performance Measure:

Number and percent of waiver participants reviewed whose Individual Service Plans (ISP) was revised as needed, to address changing needs Numerator: Total number of waiver participants who had ISPs revised as needed to address changing needs 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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of participants who are receiving services in the type, scope, amount, frequency, and duration specified in the service plan Numerator: Total number of participants who are receiving services in the type, scope, amount, frequency, and duration specified in the service plan 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:

Performance Measure:
Number and percent of waiver providers who delivered services in the type, amount, and frequency specified in the Individual Service Plan (ISP) Numerator: Total number of reviewed providers who delivered services in the type, amount and frequency specified in the ISP Denominator: Total number of providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Performance Monitoring

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:
Number and percent of waiver participant satisfaction survey respondents reporting the receipt of all services in Individual Service Plan (ISP) Numerator: Total number of returned surveys reporting receipt of all services in ISP Denominator: Total number of returned surveys with yes or no answers

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: Services My Way (SMW)
	☐ **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: Three times a year

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

Data Source (Select one):
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**	☐ **Weekly**	☑ **100% Review**

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants whose records indicate appropriately completed and signed freedom of choice forms that specifies choice was offered between institutional care and waiver services Numerator: Total number of waiver participants whose records indicated completed and signed Freedom of Choice Forms were obtained 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:

Performance Measure:
Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator: Total number of waiver participants with ISPs that documented an opportunity for choice of waiver providers and services was provided. 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:

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

Staff from the Bureau of Participant Operations (BPO) reviews 100% of new ISPs and 100% of ISPs that have a 10% change in services using the guidelines specified in the OLTL Service Plan Review Protocol (prospective review). A representative sample of ISPs is retrospectively reviewed by the Bureau of Quality and Provider Management (BQPM). These reviews are collected in the Retrospective Service Plan Review Database and the data is aggregated monthly, quarterly and yearly for tracking and trending by BQPM. Compliance for twenty nine different SP factors are reviewed and documented in the SP Retrospective Review database. Some Performance Measures (PMs) use multiple factors to determine overall compliance for the PM. Using CMS sampling parameters, BQPM tracks the sample size to ensure a statistically valid sample has been reviewed. Data regarding Services My Way (SMW) participants is stratified from the total waiver population data for tracking and trending of service plan issues for SMW participants

Data is pulled from the OLTL's Enterprise Incident Management (EIM) database regarding complaints received about service plans. BPQM reviews a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement.

BQPM reviews data from the OLTL participant satisfaction surveys for question # 12, pertaining to participant receipt of services in their ISP, and question # 13 pertaining to unmet needs. One hundred percent of returned surveys responses are monitored and aggregated three times a year.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When ISPs are reviewed for compliance and non-compliance is noted, BQPM issues a Quality Improvement Plan (QIP) to the BPO to address the non-compliance. The BPO submits a plan to correct the non-compliance to BQPM within the prescribed timeframes. As part of the QIP, BPO may contact the SC agency to remediate and follow-up on the issue. The BPO may also provide technical assistance to aid in that remediation.

Complaints regarding non-receipt of service are addressed in EIM processing, and if classified as Urgent, have a timeframe of one day for investigation initiation. See Appendix F for more information on complaint processing.

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 Attendant Care Waiver:
All participants have the right to make decisions about and self-direct their own waiver services. Participants in the Attendant Care waiver may choose to hire and manage staff using Employer Authority or manage an individual budget using Budget Authority. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

Under Employer Authority, the participant serves as the common-law the employer and is responsible for hiring, firing, training, supervising, and scheduling their support workers. Budget Authority, known in Pennsylvania as Services My Way, provides participants with a broader range of opportunities for participant-direction. Services My Way provides participants with greater flexibility, choice and control over their services, by giving participants the opportunity to: 1) select and manage staff that performs personal assistance type services under the Participant-Directed Community Supports service definition; 2) manage a flexible Spending plan; and 3) purchase allowable goods and services through their Spending plan.

How Participants May Take Advantage of Self-Directed Opportunities:
Participants may choose to self-direct their services during the development of the 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 or Budget Authority will receive support from certified Fiscal/Employer Agents (F/EA) and Service Coordinators to assist them in their role as the common-law employer of their workers. The Fiscal/Employer Agents 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
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL (Budget Authority only).

In addition, individuals choosing to self-direct their services will receive assistance from 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.

Participants who choose to manage an individual budget will receive assistance from Service Coordinators to develop the Spending Plan. The Service Coordinator will review and approve the participant's Spending Plan, and enter the plan in to HCSIS for OLTL approval. Once the Spending plan is developed, approved and authorized, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the Spending plan, the Service Coordinator will assist the participant with the execution and development of the Spending Plan and monitor spending of the Spending Plan.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **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 participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of participant direction opportunities within the waiver. The Service Coordinator documents the participant's choice of service delivery model(s) on the ISP. Participants are also advised that they have the opportunity to change their model of service at any time throughout the year. Participants receive information about participant-direction at time of enrollment, on an annual basis and upon request.

The Office of Long-Term Living has developed consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials include a comprehensive participant reference manual which contains details about participant-direction roles, responsibilities, and informed decision-making. These materials have been distributed to the Independent Enrollment Broker as well as all Service Coordination agencies, and are available on the OLTL website. This information is widely available and shared with individuals upon entering service, at monitoring contacts and during annual ISP updates each year thereafter. This information is written at a level that is easily understood using everyday common language to ensure accessibility, and is provided in advance of the ISP meeting to ensure that individuals have sufficient time to consider their options and the responsibilities.

The F/EA, 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 worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:
• Review of the information and forms contained in both the Employer and Support worker enrollment packets and how they should be completed
• The role and responsibilities of the common law employer;
• The role and responsibilities of the F/EA;
• The process for receipt and processing timesheets and employee payroll checks;
• The process for purchasing approved goods and services from vendors, including submitting invoices for payment;
• Effective practices for recruiting potential employees, hiring employees, training employees, supervising and managing employees and firing employees;
• The process for resolving issues and complaints; and
• Workers Compensation and the process for reviewing workplace safety issues.

In addition, the F/EA is responsible for providing ongoing skills training to participants and working with Service Coordinators to identify any participants who may need and/or desire additional employer skills training.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- (●) **The State does not provide for the direction of waiver services by a representative.**
- ( ) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [ ] **Waiver services may be directed by a legal representative of the participant.**
- [ ] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Participant-Directed Goods and Services	☑	☑
Personal Assistance Services	☑	☐
Participant-Directed Community Supports	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C1/C3**

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).

The Department of Public Welfare 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 Attendant Care 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] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

• Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
• Provide orientation and skills training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation;
• Conduct criminal background checks and when applicable, child abuse clearances, on potential employees;
• Distribute, collect and process support worker timesheets as verified and approved by the participant;
• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
• Broker workers' compensation for all support workers through the an appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
• Assist in implementing the state's quality management strategy related to FMS;
• Establish an accessible customer service system for the participant and the Service Coordinator;
• Assist participants in verifying support workers citizenship or alien status;
• Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only); and
• Provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL (Budget Authority only).

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**

- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

The F/EA must provide accurate and timely reports monthly to common law employers, service coordinators, and OLTL. These reports include service utilization, written notification of over and under utilization, and notification of any common law employer who does not submit timesheets for two or more consecutive payroll periods.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The statewide F/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with the OLTL F/EA contract requirements. The F/EA provides specific employer agent functions that support the participant with the employer-related functions.

The OLTL Quality Management and Efficiency Teams (QMET) conducted a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review was to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents.

OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide F/EA will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. 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 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, timeliness 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 (PERS)	☐
Service Coordination	☑
Participant-Directed Goods and Services	☐
Personal Assistance Services	☐
Community Transition Services	☐
Participant-Directed Community Supports	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities that will provide Financial management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the Attendant Care waiver. One statewide vendor F/EA was selected as a result of the RFA.

The selected F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. In addition, a one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The initial start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing

monthly per participant administrative fee The monthly administrative fee was established as part of the competitive procurement process; the one-time start-up administrative fee is established by DPW.

Participants will obtain enrollment and informational materials from the selected F/EA organization under contract with OLTL. In addition, the F/EA is responsible for providing orientation and training to the participant prior to employing their support worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:
• Review of the information and forms contained in both the Employer and Support Worker enrollment packets and how they should be completed
• The role and responsibilities of the common law employer;
• The role and responsibilities of the F/EA;
• The process for receipt and processing timesheets and employee payroll checks;
• The process for purchasing approved goods and services from vendors, including submitting invoices for payment;
• Effective practices for hiring, training, and supervising employees;
• The process for resolving issues and complaints; and
• The process for reviewing workplace safety issues.

In addition, individuals choosing to self-direct their services will receive assistance and support from their Service Coordinator. The Service Coordinator will:
• Provide participants with information regarding self-direction, including Services My Way, on an ongoing basis, including information about responsibilities, rights and concepts of self-direction;
• Work with the F/EA and the participant as necessary to ensure all enrollment and employment paperwork is completed and sent to the F/EA;
• Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services;
• Assist the participant to develop job descriptions for support workers to be employed by the participant. Job descriptions must be consistent with the individual service plan;
• Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.
• Assist the participant in communicating with the F/EA as needed;
• Support the participant in problem-solving, decision-making, and recognizing and reporting critical incidents; and
• Monitor the provision and utilization of services to ensure the participant's health and welfare.

In addition to the above, the Service Coordinator is also responsible for the following activities when the participant chooses to exercise budget-authority:
• Explain the method for developing the individual budget and share the budget amount with the Participant during the ISP process;
• Assist the participant in developing the individual spending plan if requested to do so;
• Ensure that allowable expenditures for goods and services are made using the participant's individual budget;
• Counsel the participant on the budget and other issues as necessary;
• Assist the participant with service plan modifications within limits of the individual budget; and
• Notify the F/EA regarding changes to the individual budget and spending plan.

The OLTL 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

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k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants have the option to transition from participant direction to the provider managed service delivery model by contacting their Service Coordinator who will guide them through the process of transition. When a participant voluntarily chooses to terminate participant direction, they will notify their Service Coordinator. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period.

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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants 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		7529
Year 2		7529
Year 3		7529
Year 4		7529
Year 5		7529

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**

- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

To ensure all participants make an informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services. The FMS agency secures and pays for the criminal background check.

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **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:*

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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant directed budget is developed based on the Individual Service Plan (ISP). The amount of the individual budget is based on the amounts of service that are authorized in the ISP and are reflected in a participant's Spending Plan. The process for ISP development is the same for all participants in the Attendant Care Waiver, regardless of service model. The Service Coordinator reviews the participant's needs with the participant and ensures that the ISP includes sufficient and appropriate services and provides the support that an individual needs or is likely to need in the home and community and to avoid institutionalization. Once the participant determines that they wish to self-direct, the number of units of Personal Assistance Services are multiplied by the average regional agency rate for Personal Assistance Services (Procedure Code W1793). This monetized amount represents the participant's individual budget amount and represents the amount that would have been paid on the participant's behalf if they used provider-managed services. Service Coordination and the monthly F/EA service fee is not included in the participant's individual budget amount and is not reflected in the participant's Spending Plan.

The Service Coordinator is responsible for explaining the method for developing the individual budget and sharing the budget amount with the Participant during the ISP process. The participant works with the Service Coordinator to determine how the budget can be utilized to best serve their needs while maintaining their health and welfare.

A Spending Plan is developed that uses the available monies to purchase goods and services in a manner that allows the participant increased control and flexibility in the way their services are delivered. The Spending Plan is a detailed plan that describes what, how much and from whom the participant will obtain goods and services that meet his/her needs as identified in the individual service plan. The Spending Plan also identifies the timing for spending throughout the timeframe of the participant's plan. The F/EA must pay the invoices in accordance with the Spending Plan as authorized by the participant.

Information about participant-directed services, including the method for determining the individual budget, is made available through the Services My Way (SMW) training manual, online and the standard participant information materials developed by OLTL.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

During the ISP process, the Service Coordinator notifies the participant of the individual budget amount following the approval of the ISP by the OLTL, and assists the participant in developing the individual spending plan if requested to do so. In the event that participant needs change, the participant may request an adjustment to their individual budget by contacting their Service Coordinator. As described in Appendix D, the Service Coordinator will reassess the participant's needs and .request approval of the revision from OLTL as appropriate. The participant will be notified of the approval or denial of the request. The participant has the right to the fair hearing and appeals process as outlined in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants have flexibility to manage their services and modify their Spending Plan without requiring the prior preparation of a revised Service Plan. Funds in the participant's Spending Plan may be reallocated without modifying the service plan when:
1. The participant wants to change an employee's start time.
2. The participant wants to distribute work hours more evenly by assigning more hours to one employee, and this change will not exceed the budget limit.
3. The participant wants to change how an employee will do assigned tasks.
4. The participant wants to reschedule an employee from one day to the next.
5. The participant needs to use the back-up plan.

Participants must notify the F/EA when they plan to exercise their authority to reallocate funds prior to implementing the changes. Upon making the change the participant must meet with the Service Coordinator to document the changes in the Spending Plan.
Any changes that do not meet the criteria above require a change to the ISP and the Service Coordinator's submission to OLTL for approval prior to implementation. To initiate a change of this scope, the participant must meet with his/her Service Coordinator to amend their service plan and Spending Plan. The Service Coordinator will review and approve the amendment. Once the approval is granted the participant will submit an amended plan to the F/EA.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monitoring oversight of the Spending plan is the dual responsibility of the Service Coordinator and the F/EA. The F/EA will provide written financial reports to the participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and OLTL. The participant, Service Coordinator and OLTL will receive written notification from the F/EA when utilization exceeds the monthly budget by 10% or more or when utilization is 80% or less.

The participant is responsible for developing a monthly Spending Plan, with assistance as needed, which will be approved and authorized by the Service Coordinator, and will be utilized to track over and under expenditures.

The F/EA will monitor expenditures, flag significant budget variances, and ensure that the purchase of goods and services and submitted timesheets match the participant's Spending Plan. The F/EA will not reimburse

services not documented or authorized in the Spending Plan.

The Service Coordinator will track under-utilization and over-utilization and contact the participant and OLTL to resolve potential service delivery problems. The Service Coordinator must monitor the Spending Plan to assure that expenditures remain consistent with the individual budget, and review the monthly financial reports for the following:
• Under Spending – the participant spends less than 80% of what was authorized for the month, unless there was a hospitalization or other reason for low spending;
• Uneven Spending – the participant's employee's hours are disproportionately being used, e.g., the first two weeks at 75% and the last two weeks at 25%;
• Additional Hours – the participant's employees are being paid additional hours;
• Turnover – high turnover of employees. This should be reviewed over a series of months; and
• Excessive use of agency services for gap filling purposes instead of using back-up services.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with OLTL policies. A participant will have his or her rights to file a fair hearing request discussed at time of enrollment, annually during the ISP annual review meeting and at any time the participant requests to change services or add new services.

The IEB 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 IEB/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/IEB 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 Office of Quality Management, Metrics and Analytics and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services, provider performance, 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.
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.
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. 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.
9. Medication errors that require medical intervention, for example, hospitalization, or emergency room visits.

Individuals/entities that are required to report critical events:
Per 55 PA Code Chapter 52 and OLTL's Critical Incident Management Bulletin, administrators and employees of waiver service providers, including Service Coordination Entities, and individual providers of waiver services, are responsible for reporting critical incidents, as defined above, to OLTL. In addition, Direct service providers are required to notify the participant's Service Coordinator when a critical incident occurs.

In addition to reporting an incident to OLTL, in the event a provider 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 to the local Older Protective Services Agency and the Department of Aging. The provider must also immediately contact the appropriate law enforcement official to file a report. In the event a provider has reasonable suspicion that a participant under age 60 is the victim of abandonment, abuse, exploitation, intimidation, neglect, serious injury or bodily injury or sexual abuse, the provider must report to the Adult Protective Services Office of the Department of Public Welfare in addition to reporting to OLTL. 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 incident 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 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. 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.
BQPM 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 Quality and Provider Management (BQPM) and the Bureau of Participant Operations (BPO) are together 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 (6 PA Code Chapter 15), the Department of Public Welfare's Adult Protective Services Act (Act of October 7, 2010, P.L. 484, No. 70) 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 for additional investigation and 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 entity that has firsthand knowledge of the incident (Service Coordinator or Direct Service provider) is responsible to for conducting an investigation unless there is reason to believe that the provider or service coordinator will not be objective in the conduct of such investigation. The entity has 30 days from the initial report to provide all the information regarding the incident to the OLTL.

If the incident meets the standards of 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 or Direct Service providers 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.

All allegations of abuse, neglect and exploitation are reported to the Bureau of Participant Operations staff, who works directly with the participant's Service Coordinator for possible further investigation. In cases investigated under protective services, the Service Coordinator works with the protective service worker to ensure the health and welfare of the participant, and revises the service plan to meet the participants' needs and to mitigate the allegations when appropriate.

In rare circumstances in cases where an OLTL staff onsite is required due to egregious circumstances, BQPM and BPO staff conducts a joint onsite review. Cases are thoroughly investigated and the investigation is documented. The investigative staff provides recommendations when provider non-compliance is identified including issuing 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 and the Office on Long Term Living 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. The Department of Public Welfare is in the process of procuring Adult Protect Services and has set up an interim process that will utilize the Department of Aging's program where appropriate.

See Appendix H Quality Improvement Strategy for additional information.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or 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 restraints and seclusion. 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 and restrictive interventions 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 or seclusion.

The Office of Long Term Living is notified about unauthorized use of restraints or 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 unauthorized use of restraints or seclusion, 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 authorized restraints or 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 or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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 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 and 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 restraints and 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 authorized restraints or 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 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-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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **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.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants with more than three (3) reported incidents within the past 365 calendar days. Numerator: Total number of waiver participants with more than three (3) reported incidents within the past 365 calendar days. Denominator: Total number of waiver participants with reported incidents within the past 365 calendar days.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incidents reports – EIM

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: Services My Way Participants
	☐ **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:
Number and percent of incidents reported within the required timeframe. Numerator: Total number of incidents reported within the required timeframe. Denominator: Total number of incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incidents reports – EIM

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: Services My Way Participants
	☐ **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:
Number and percent of Reportable incidents investigated within the required timeframe Numerator: Total number of Reportable incidents investigated within the required timeframe. Denominator: Total number of incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incidents reports – EIM

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

(check each that applies):	*(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: Services My Way Participants
	☐ **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:
Number and percent of New Waiver participants, responding to the Satisfaction Survey, who indicate knowledge of how to report abuse, neglect, or exploitation (ANE).
Numerator - Total number of New Waiver participants responding to the Participant Satisfaction Survey, who indicate "yes" - knowledge of how to report abuse, neglect, or

exploitation (ANE). ***See Main-B-Optional for rest

Data Source (Select one):
Other
If 'Other' is selected, specify:
Returned Surveys

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: Services My Way Participants
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Three times a year	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of Annual Waiver participants, responding to the Satisfaction Survey, who indicate knowledge of how to report abuse, neglect, or exploitation (ANE). Numerator - Total number of "Annual" Waiver participants responding to the Participant Satisfaction Survey, who indicate "yes" - knowledge of how to report abuse, neglect, or exploitation. ***See Main-B-Optional for rest

Data Source (Select one):
Other
If 'Other' is selected, specify:
Returned Surveys

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: Services My Way Participants
	☐ **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:
Number and percent of Urgent complaints investigation initiated within required timeframe. Numerator: Total number of Urgent complaints investigated within required timeframe. Denominator: Total number of Urgent incidents investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database – EIM

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: Services My Way Participants
	☐ **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:
Number and percent of Non-Urgent complaints investigated within required timeframe. Numerator: Total number of Non-Urgent complaints investigated within required timeframe. Denominator: Total number of Non-Urgent complaints investigated

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database – EIM

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: Services My Way Participants
	☐ **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:
Number and percent of complaints, investigated/closed within required timeframe. Numerator: Total number complaints, closed within required timeframe. Denominator: Total number complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database – EIM

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: Services My Way Participants
	☐ **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:
Number and percent of Waiver Participants who were informed of the reporting process for abuse, neglect, and exploitation. Numerator: Total number of Waiver Participants who were informed of the reporting process for abuse, neglect, and exploitation. Denominator: Total number of Waiver Participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Plan Retrospective Review 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 = 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.
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.

Data regarding Services My Way (SMW) participants is stratified from the data for the total waiver population. The data is used for tracking and trending of Health & Welfare issues for SMW participants from the incident, complaint and survey data.

Please see Appendix H for more information regarding the Assurance 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 Unit (QMEU) 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 Unit for a targeted review and possible Corrective Action Plan (CAP). The BQPM also refers these participants to BPO through the Quality Improvement Plan process (QIP) under the standard of ensuring health and welfare. Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G.

If the BQPM discovers that a complaint was not acted upon in accordance with waiver standards, the BQPM issues a Statement of Finding and requests a QIP from the BPO.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

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 Office of Long-Term Living (OLTL) has built upon our strong commitment to quality by developing the

Bureau of Quality and Provider Management (BQPM). The BQPM was created to support the other OLTL Bureaus and programs in maintaining continuous quality improvement.

The Quality Improvement Strategy

The BQPM's work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to OLTL systems, and then monitoring system improvement changes for effectiveness.

The process for trending discovery and remediation information (data) begins with the BQPM receiving the data from various points in the OLTL system for the various Assurance performance measures. Database aggregation reports are produced for the BQPM to trend various aspects of quality including the six CMS quality assurances: administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. Additionally, to support the administrative data, the BQPM reviews information for the performance measures from various discovery activities such as field observations, record reviews, and participant satisfaction surveys.

Provider remediation activities are documented in Corrective Action Plans (CAPs) which are requested from providers by the QMETs to correct non-compliance issues. See the Quality section in Appendix C for more information on QMET remediation. Remediation activities within OLTL are documented in Quality Improvement Plans (QIPs) which are requested by the BQPM for internal remediation within a single bureau. The CAPs and QIPs are then aggregated for the BQPM to review, track trends, and suggest system changes. System changes are considered for the completion of a System Improvement Plan (SIPs) to document and implement system-wide changes.

In order to manage and prioritize the quality management issues, the BQPM has assigned each of the six Waiver Assurances to a Quality Management (QM) Assurance Liaison, who works for the Quality Management Division. The QM Assurance Liaison reviews the various quality reports through tracking and trending, and determines possible causes of irregular data or compliance issues. Quality data is gathered for the performance measures from numerous sources, including provider monitoring by the QMETs, surveys, administrative data, etc., and aggregated for tracking and trending.

The QM Assurance Liaison makes initial recommendations and prioritizes issues that require system change or corrective measures. The QM Assurance Liaisons review and respond to aggregated, analyzed discovery and remediation information collected on each of the assurances. Each QM Assurance Liaison communicates regularly with other bureaus within OLTL to discuss findings from the data reports, including trends. The bureaus provide necessary clarifications regarding the data and possible trends. In addition to trending and analyzing for each waiver, this structure allows the BQPM to trend and analyze across multiple waivers.

The BQPM internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM Assurance Liaison, an expedited process of review is implemented. The BQPM summarizes the list of priorities and recommendations in a periodic report to present to the Quality Management Meeting (QM2). QM2 meets regularly during the month prior to Quality Council's meeting. The QM2 participants consist of appropriate BQPM staff, OLTL Bureau directors (or designee) and internal subject matter experts. The comments and input from the QM2 are considered and included in revised reporting for the Quality Council. The Quality Council is comprised of internal and external stakeholders, whose recommendations are reviewed by the Director of the BQPM. Recommendations could include formal or informal System Improvement Plans (SIPs). The Director makes final recommendations as to action needed for system improvements to the Deputy Secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

Bureau of Quality & Provider Management Goals

The goals of the BQPM are:
• To conduct quality monitoring of long term living programs and services to ensure compliance with Federal and State regulations

• To use data analysis to measure effectiveness of program design and operations

• To recommend strategies for Continuous Quality Improvement

• To establish a quality improvement focus within OLTL based on the Six Waiver Assurances and their sub-

assurances:
o Level of Care - LOC
o Qualified Providers - QP
o Service Plan - SP
o Health and Welfare - HW
o Financial Accountability - FA, and
o Administrative Authority - AA

• To support OLTL management in development and implementation of policies and protocols to achieve desired outcomes

• To oversee the development of system wide training for staff, providers and participants

• To work effectively with other OLTL Bureaus, internal and external stakeholders, other State Agencies, contracted consultants, the Quality Council, and other individuals or entities regarding Quality Management activities.

The mission of the BQPM is to meet these goals in a manner which will bring about maximization of the quality of life, functional independence, health and well being, and satisfaction of participants in OLTL programs and waivers.

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 BQPM assists the Bureau of Participant Operations (BPO) in developing quality management improvement strategies for the needed system design changes. The BQPM ensures the strategies are implemented, evaluating the effectiveness of the strategies against tracked and trended data. Additional reports to narrowly track the effect of system changes are developed and produced by Metrics & Analytics, and given to the BQPM for analysis. The analyses are reviewed in the same manner as other reports through the QM liaison, QM2 and Quality Council creating a cycle of continuous quality improvement.

Relevant system changes that directly affect stakeholders are broadly communicated to the public via pre-established forums such as OLTL program directives, stakeholder membership groups, listservs, websites, webinar(s), and direct mailing on a periodic basis.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy (QIS) is evaluated on an on-going and continuous basis through the implementation of the continuous quality cycle. Periodic evaluation also occurs every two years when the QIS is reviewed by the QM2 and the Quality Council.

The Quality Improvement System outlined also applies to the Aging (control number 0279), OBRA (control

number 0235), Independence (control number 0319), CommCare (control number 0386) and AIDS (control number 0192) Waivers. OLTL has incorporated all of OLTL's 1915 (c) waivers into a global Quality Improvement Strategy. The discovery and remediation data gathered during the implementation of the QIS are waiver specific and stratified. Because the renewals are staggered, the QIS automatically receives a periodic evaluation during the point of the renewal of each waiver.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following are the audit and financial review requirements to ensure the financial integrity of the waiver program as specified in PA Code §52.43 Audit Requirements:

1. Providers shall comply with the Federal audit requirements as specified in Section 74.26 of 45 CFR (relating to non-Federal audits).

2. Providers who meet certain thresholds as specified in OMB Circular A-133, as revised, and the Department of Public Welfare's (DPW) Annual Single Audit Supplemental Publication are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502, as amended, and to complete DPW's annual Single Audit Supplement publication.

3. Providers who which are not required to comply with the Singe Audit Act of 1984 during any program year shall maintain auditable records in compliance with PA Code §52.43.

4. DPW may request that a provider have the provider's auditor perform an attestation engagement; DPW or DPW's designee may perform an attestation engagement; or DPW may request that the provider's auditor conduct a performance audit in accordance with the following:
a) Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards.
b) Standards issued by the Auditing Standards Board.
c) Standards issued by the American Institute of Certified Public Accountants.
d) Standards issued by the International Auditing and Assurance Standards Board.
e) Standards issued by the Public Company Accounting Oversight Board.
f) Standards of successor organizations to those organizations in paragraphs a. through e. above.

In all cases, providers must retain auditable records for at least 5 years from the provider's fiscal year-end. If the provider has a settlement of claims as a result of litigation, then the provider must retain auditable records 5 years from the end date of the litigation or 5 years from the provider's fiscal year-end, whichever is greater. Additionally, the provider must retain records beyond the 5 year period DPW or another State or Federal agency has unresolved questions regarding costs or activities of the provider.

Payments to providers are also controlled by edits built into the Commonwealth's MMIS system known as PROMISe. Claims for services are matched against the eligibility system (CIS) so that payments are not made for recipients that have not been approved for Medicaid and for the waiver. Additionally, the PROMISe system will not pay claims if a participant does not have either the service or the provider included in the approved service plan for the recipient in the HCSIS system.

The Office of Long Term Living's (OLTL), Quality Management Efficiency Teams (QMET) conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. In order to conduct these post payment reviews, the QMET's review PROMISe claims reports against provider's time sheets, paid invoices and other sources provided to verify accuracy of services rendered.

Depending on the findings of the QMET reviews, remediation may include:
• Suspending claims pending review prior to payment

• Review of provider's records
• Review of provider's written billing policies/procedures.
• Sanctions, prohibition or disenrollment from providing services.
• Prohibition from serving new participants
• Provider refund of inappropriately billed amounts

Providers may also be selected for a GAGAS performance audit by the DPW Bureau of Financial Operations.

If issues of financial fraud and abuse are suspected, OLTL through the DPW Office of General Counsel (OGC) will refer such issues to the DPW Office of Medical Assistance Programs (OMAP), Bureau of Program Integrity (BPI) for review, investigation, and appropriate action.

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.
   i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of claims coded as specified by the Department of Public Welfare.
Numerator: Total number of claims that paid as specified by the Department.
Denominator: Total number of paid claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers submitting accurate claims for services authorized by the waiver and being paid for those services. Numerator: Total number of providers, of those reviewed, who submit accurate claims for waiver services. Denominator: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Performance Monitoring

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:
Number and percent of Services My Way participants who spend 80% or less of their spending plan. Numerator: Total number of Services My Way participants who spend 80% or less of their spending plan. Denominator: Total number of Services My Way participants.

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

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

(check each that applies):	*(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:
Number and percent of Services My Way participants who are directed to other service models because of non-authorized use of funds. Numerator: Total number of Services My Way participants who are directed to other service models because of non-authorized use of funds. Denominator: Total number of Services My Way participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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**
	☐ **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 is processed by OLTL Bureau of Quality & Provider Management (BPO) against all paid waiver claims (100% sample) on a monthly basis, within the PA PROMISe MMIS claims processing system to verify that only valid procedure codes are paid. The Financial Accountability (FA) Assurance Liaison aggregates the reports for longitudinal monitoring.

The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. Using a standard monitoring tool which incorporates the Financial Accountability requirements as listed in the waiver, the QMET verifies each requirement during the review. 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.

Services My Way reports are prepared by the OLTL Financial Management Services vendor using a combination of Administrative Data, HCSIS and payroll, in a 100% sample, on a monthly basis. The Financial Accountability (FA) Assurance Liaison analyzes the data to determine performance measure factors.

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.

Noncompliance discovered during QMET monitoring is remediated through Corrective Action Plans (CAPs), requiring providers to submit their action steps to remedy their non-compliance.

Services My Way Administrative Data reports are prepared by the Financial Management Services vendor for both under and over usage of SWM spending plans, and are accessed by OLTL for the performance measures above. The Bureau of Participant Operations (BPO) regional representatives contact the Service Coordinators to request a review of the spending plan and counseling of the participant as needed. Follow up will be taken by OLTL as needed. The BQPM will review service notes and contact SCs as needed to determine reasons for termination from SMW. Results will be analyzed for possible improvements to the Service My Way model.

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 Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Medical Assistance Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definitions, a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in Department standards and a review of cost data as supplied from providers. The fee schedule rates represent the maximum rates that DPW will pay for each service. In developing rates for each of the MA fee schedule services, the following occurs:
• OLTL evaluates various independent data sources such as Pennsylvania-specific compensation data supplied by the PA Bureau of Labor Statistics and considers the expected expenses for the delivery of the services under the waivers for the major allowable cost categories listed below:
-Wages for staff
-Employee-related expenses
-Productivity
-Program Indirect expenses
-Administration-related expenses
• OLTL develops geographical fees to reflect consideration for differences in wages observed across the Commonwealth.
• The fee schedule rates are established by the Department to fund the fee schedule services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.
• Rates for the following services are on the waiver fee schedule: personal assistant services and service coordination.
• Additionally, OLTL reimburses the following services: Community Transition Services, Participant Directed Community Supports, Participant Directed Goods and Services and Personal Emergency Response System based on the cost charged to the general public for the good or service.
• Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.
• Once published in the Pennsylvania Bulletin, the rate notice and corresponding rates are available on the OLTL website for participants, providers and the general public's information. In addition, when the participant chooses to self-direct some or all of their services, the F/EA is responsible for informing the participant of the established rate for that service.

OLTL obtained public comment on the rate determination methods in a variety of formats which include, stakeholder workgroup discussions, draft documents distributed for comment, communications and other meetings.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Providers are reimbursed retrospectively based on services provided.

Providers must submit claims through PROMISe, DPW's MMIS system. This system is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS).

In order to be paid for submitted claims, providers must be enrolled as Medical Assistance providers and entered as such into PROMISe.

PROMISe verifies participant information in the Client Information System (CIS) which contains MA participant's eligibility information, such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates.

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 participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Attendant Care Waiver.

After validation of the above listed items occurs, the claim information is sent to the Home and Community Services Information System (HCSIS) to be verified against the participant's ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This fiscal accountability of services rendered provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. Resolutions of denied or suspended claims occur through error code notification.

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for and the cost of services provided under the waiver. OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. OLTL reviews HCSIS reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews. Finally, Service Coordinators are responsible for ensuring the proper information is entered into HCSIS correctly so providers can bill timely and accurately. Service Coordinators are responsible for monitoring the participant's ISP to ensure the participant is receiving the services as authorized in the ISP.

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: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a. Entities eligible for designation as OHCDS for services within this waiver are service coordination entities, all of which render at least one Medicaid service directly (Service Coordination) utilizing its own

employees.
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:
Do not complete this item.

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20164.99		28911.80			69914.49	41002.69
2	20164.99		29308.46			70080.78	40772.32
3	20164.99		29705.12			70247.07	40541.95
4	20164.99		30101.77			70413.35	40311.58
5	20164.99		30498.43			70579.64	40081.21

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	10000	10000
Year 2	10000	10000
Year 3	10000	10000
Year 4	10000	10000
Year 5	10000	10000

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 2006-2007 through 2010-2011 and 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 both DPW's MMIS system, PROMISe and Client Information System (CIS). Specifically, paid claims with a last date of service were obtained from PROMISe and waiver eligibility segments were obtained from CIS for the 5 year period as noted above. This same data is used 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:

In order to calculate the Factor D Derivation, paid claims data from DPW's MMIS system, PROMISe, from SFY 2010-2011 was analyzed. This is the same data source that is used for submission of the CMS 372.

Column 1 (Unit) and Column 4 (Average Cost per Unit), in the estimate of Factor D below are based on rates set as specified in the rate setting methodology described in Appendix I and published in the Pennsylvania Bulletin. Column 4 (Average Cost per Unit) is an average of the four regional rates. Since these rates have been in place less than 1 year, sufficient historical data is not available to weight these averages based on utilization by region. The schedules below do not reflect any changes to the average rates over the course of the five year renewal. OLTL will review these rates in relation to quality and access and make any necessary changes in the future utilizing our rate setting methodologies as specified in Appendix I.

Column 2 (Users) was determined by calculating the percentage of actual users for each service for the period of SFY 2010/2011 from paid claims in the PROMISe system and then multiplying by the number of unduplicated users in Table J-2-a. OLTL has made significant changes to offered services within the past year either per our regulations as found in Chapter 52 or per the corrective action plan in place for this waiver. For former services that have been removed or combined, the actual users were modified based on remaining or new services that are most similar. As further data becomes available, OLTL may need to make modifications in the users.

Column 3 (Average Units) were determined by dividing the number of total units by the number of actual users for each service. This calculation was derived by utilizing data from paid claims retrieved from the PROMISe system for SFY 2010/2011. As stated above, OLTL has made significant changes to both our services offered and to the units for many services. In the case where services have been removed or modified, units for this renewal were modified based on remaining or new services that are most similar. As further data becomes available, OLTL may need to make modifications in the average units.

Additionally, due to lack of historical data of average units based on revised the changes made to service definitions, units and rates the Factor D Derivation remains flat in all respects over the five year renewal period.

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 five year period of SFY 2006-2007 through SFY 2010-2011 obtained from DPW's MMIS system, PROMISe for waiver participants that also had acute care paid claims. The data from the five year period specified above was then projected forward for the renewal period by dividing acute care costs by unduplicated participants and utilizing a computerized

forecasting tool.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The G factor was formulated based on date from DPW's MMIS system, PROMISe. Paid claims to nursing facilities for the period of SFY 2010-11 for individual's ages 18 years or older but not yet age 60 were pulled from PROMISe and analyzed to determine an average daily rate. This rate was then annualized to determine the G factor. For the five year period prior to this SFY, nursing facility rates had remained relatively flat and it is anticipated that this will continue over the five year renewal period due to both transitioning initiatives and economic drivers.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

G' factor was formulated by reviewing paid claims data for SFY 2010-2011 obtained from DPW's MMIS system, PROMISe, for persons over the age of 18 utilizing nursing facility services who also had acute care paid claims including the deduction of Medicare Part D drug costs. The date was then projected forward for the renewal period by dividing acute care costs by unduplicated nursing facility residents and utilizing a computerized forecasting tool.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Personal Assistance Services
Service Coordination
Community Transition Services
Participant-Directed Community Supports
Participant-Directed Goods and Services
Personal Emergency Response System (PERS)

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
Personal Assistance Services Total:						**174786369.87**
Personal Assistance Services Agency	15 Min	2766	3362.00	4.58	**42590757.36**	
Personal Assistance Services Participant Directed	15 Min	7529	5031.00	3.49	**132195612.51**	
Service Coordination Total:						**26136000.00**

Service Coordination	15 Min	10000	144.00	18.15	**26136000.00**	
Community Transition Services Total:						**26556.93**
Community Transition Services	One Time	9	1.00	2950.77	**26556.93**	
Participant-Directed Community Supports Total:						**111319.20**
Participant-Directed Community Supports	Per Purchase	5	18.00	1236.88	**111319.20**	
Participant-Directed Goods and Services Total:						**12014.04**
Participant-Directed Goods and Services	Per Purchase	3	2.00	2002.34	**12014.04**	
Personal Emergency Response System (PERS) Total:						**577643.04**
Personal Emergency Response System (PERS)	Per Purchase	2092	9.00	30.68	**577643.04**	
				GRAND TOTAL:		**201649903.08**
				Total Estimated Unduplicated Participants:		**10000**
				Factor D (Divide total by number of participants):		**20164.99**
				Average Length of Stay on the Waiver:		278

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
Personal Assistance Services Total:						**174786369.87**
Personal Assistance Services Agency	15 min	2766	3362.00	4.58	**42590757.36**	
Personal Assistance Services Participant Directed	15 min	7529	5031.00	3.49	**132195612.51**	
Service Coordination Total:						**26136000.00**
Service Coordination	15 Min	10000	144.00	18.15	**26136000.00**	
Community Transition Services Total:						**26556.93**
Community Transition Services	One Time	9	1.00	2950.77	**26556.93**	
Participant-Directed Community Supports Total:						**111319.20**
Participant-Directed Community Supports	Per Purchase	5	18.00	1236.88	**111319.20**	
Participant-Directed Goods and Services Total:						**12014.04**

Participant-Directed Goods and Services	Per Purchase	3	2.00	2002.34	**12014.04**	
Personal Emergency Response System (PERS) Total:						**577643.04**
Personal Emergency Response System (PERS)	Per Purchase	2092	9.00	30.68	**577643.04**	
			GRAND TOTAL:			**201649903.08**
			Total Estimated Unduplicated Participants:			**10000**
			Factor D (Divide total by number of participants):			**20164.99**
			Average Length of Stay on the Waiver:			278

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services Total:						**174786369.87**
Personal Assistance Services Agency	15 min	2766	3362.00	4.58	**42590757.36**	
Personal Assistance Services Participant Directed	15 min	7529	5031.00	3.49	**132195612.51**	
Service Coordination Total:						**26136000.00**
Service Coordination	15 Min	10000	144.00	18.15	**26136000.00**	
Community Transition Services Total:						**26556.93**
Community Transition Services	One Time	9	1.00	2950.77	**26556.93**	
Participant-Directed Community Supports Total:						**111319.20**
Participant-Directed Community Supports	Per Purchase	5	18.00	1236.88	**111319.20**	
Participant-Directed Goods and Services Total:						**12014.04**
Participant-Directed Goods and Services	Per Purchase	3	2.00	2002.34	**12014.04**	
Personal Emergency Response System (PERS) Total:						**577643.04**
Personal Emergency Response System (PERS)	Per Purchase	2092	9.00	30.68	**577643.04**	
			GRAND TOTAL:			**201649903.08**
			Total Estimated Unduplicated Participants:			**10000**
			Factor D (Divide total by number of participants):			**20164.99**
			Average Length of Stay on the Waiver:			278

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services Total:						**174786369.87**
Personal Assistance Services Agency	15 min	2766	3362.00	4.58	**42590757.36**	
Personal Assistance Services Participant Directed	15 min	7529	5031.00	3.49	**132195612.51**	
Service Coordination Total:						**26136000.00**
Service Coordination	15 Min	10000	144.00	18.15	**26136000.00**	
Community Transition Services Total:						**26556.93**
Community Transition Services	One Time	9	1.00	2950.77	**26556.93**	
Participant-Directed Community Supports Total:						**111319.20**
Participant-Directed Community Supports	Per Purchase	5	18.00	1236.88	**111319.20**	
Participant-Directed Goods and Services Total:						**12014.04**
Participant-Directed Goods and Services	Per Purchase	3	2.00	2002.34	**12014.04**	
Personal Emergency Response System (PERS) Total:						**577643.04**
Personal Emergency Response System (PERS)	Per Purchase	2092	9.00	30.68	**577643.04**	
GRAND TOTAL:						**201649903.08**
Total Estimated Unduplicated Participants:						**10000**
Factor D (Divide total by number of participants):						**20164.99**
Average Length of Stay on the Waiver:						278

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services Total:						**174786369.87**
Personal Assistance Services Agency	15 min	2766	3362.00	4.58	**42590757.36**	
Personal Assistance Services Participant Directed	15 min	7529	5031.00	3.49	**132195612.51**	
Service Coordination Total:						**26136000.00**
Service Coordination	15 Min	10000	144.00	18.15	**26136000.00**	
Community Transition Services Total:						**26556.93**
Community Transition Services	One Time	9	1.00	2950.77	**26556.93**	
Participant-Directed Community Supports Total:						**111319.20**
Participant-Directed Community Supports	Per Purchase	5	18.00	1236.88	**111319.20**	
Participant-Directed Goods and Services Total:						**12014.04**
Participant-Directed Goods and Services	Per Purchase	3	2.00	2002.34	**12014.04**	
Personal Emergency Response System (PERS) Total:						**577643.04**
Personal Emergency Response System (PERS)	Per Purchase	2092	9.00	30.68	**577643.04**	

GRAND TOTAL:	**201649903.08**
Total Estimated Unduplicated Participants:	**10000**
Factor D (Divide total by number of participants):	**20164.99**
Average Length of Stay on the Waiver:	278